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ABSTRACT

The Subcommittee met in the first of a series of hearings on graduate medical education aimed at developing a new Medicare health professional education and teaching hospital payment policy. The hearing examined new policies for training future health professionals, future medical manpower needs, and the financing of teaching hospitals. Current Medicare payment mechanisms for graduate medical education and teaching hospitals were also reviewed. Among the witnesses were representatives of the American College of Surgeons advocating continued support for teaching hospitals, the American Dental Association advocating continued funding for hospital-based graduate dental education, the American Medical Association in favor of adding third-party payers' support for graduate medical education, the American Nurses Association advocating increased support for graduate nursing education, the American Osteopathic Association advocating limiting residency funding to 110 percent of total graduates, the American Podiatric Medical Association in favor of all third-party payers sharing in the support of graduate training, the Harvard Community Health Plan advocating different allocation to training sites, and the Association of American Medical Colleges on two specific Medicare payments. Also appearing were Doctor Kenneth Shine, Doctor Robert Heyssel, Professor Ruth S. Hanft, and Nurse Michael A. Carter. Includes the prepared testimony of witnesses and six submissions for the record. (JB)

ISSUES REGARDING GRADUATE MEDICAL EDUCATION

ED 390 356

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 23, 1995

Serial 104–17

Printed for the use of the Committee on Ways and Means

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ISSUES REGARDING GRADUATE MEDICAL EDUCATION

THURSDAY, MARCH 23, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
March 14, 1995
No. HL-6

CONTACT: (202) 225-3943

THOMAS ANNOUNCES HEARINGS ON ISSUES REGARDING GRADUATE MEDICAL EDUCATION -- A VISION FOR THE FUTURE

Congressman Bill Thomas (R-CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the subcommittee will conduct the first of a series of hearings on the topic of graduate medical education. **The hearing will take place on Thursday, March 23, 1995, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Since the inception of the Medicare program in 1965, Medicare has reimbursed teaching hospitals for the program's share of the cost of training physicians and other health professionals, and the generally higher costs of operating tertiary-care academic health centers. With the advent of the Medicare Prospective Payment System in 1983, Medicare hospital payment for graduate medical training and certain teaching hospital service costs has been separated into direct and indirect reimbursement for medical education.

Medicare pays for the allowable cost of direct graduate medical education activities at teaching hospitals, including reimbursement for training and related overhead costs, and salaries and fringe benefits for medical residents and other health professionals. Medicare is expected to reimburse teaching hospitals $1.9 billion for the direct costs of graduate medical education in 1995.

The Medicare indirect medical education adjustment compensates teaching hospitals for the costs of the additional tests and procedures which occur in those hospitals related to the training of medical residents, as well as the fact that these hospitals tend to treat sicker, and generally poorer, elderly patients who require more intensive services. In order to cover these extra costs, teaching hospitals receive a higher payment per case than other institutions. This per case add-on is currently set at approximately 7.7 percent for each 10 percent increase in the ratio of full-time interns and residents to the number of beds in the hospital. In 1995, Medicare is projected to spend $3.6 billion on the indirect medical education adjustment.

In announcing the hearing, Chairman Thomas said: "A revolution is underway in health care which has significant implications for the future health manpower needs of the nation as well as the destiny of our major teaching hospitals. As we consider significant Medicare and health reforms, the Health Subcommittee will examine carefully current graduate medical education and teaching hospital policy, and the effect Medicare policy improvements can have on the ultimate direction for both graduate medical education and academic health centers."

FOCUS OF THE HEARING:

This hearing is the first of a series on the topic of graduate medical education with the goal of developing a Medicare health professions education and teaching hospital payment policy relevant to the emerging health care system and the long-run medical and financial concerns of Medicare beneficiaries. The hearing will examine alterative policy directions regarding the

training of future health professionals, the medical manpower needs of the evolving health care system, and the financing of teaching hospitals. Current Medicare payment mechanisms for graduate medical education and teaching hospitals will be reviewed.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Monday, April 3, 1995, to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available over the Internet at GOPHER.HOUSE.GOV, under "HOUSE COMMITTEE INFORMATION".

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Chairman THOMAS. The subcommittee will come to order.

We want to welcome you to the first of a series of hearings on graduate medical education. These hearings hopefully will lay a base for the development of new Medicare policies on reimbursement for graduate medical education and the payment for services in teaching hospitals.

These new policies should be consistent with the medical and financial concerns of Medicare beneficiaries and the evolving health care marketplace.

To meet these goals, we will be looking for new ideas and better ways of using our Medicare resources and, in some instances, repeating ideas of 10 years ago that we did not listen to at that time.

The question before us today is: How do we provide incentives for making the training of doctors and health care professionals more relevant to the needs of Medicare beneficiaries in the emerging health care marketplace, which is also consistent with our objectives for maintaining our superior hospital system and containing Medicare cost growth. These challenges will obviously be a critical part of our broader task to preserve and improve the Medicare program.

There is a growing consensus that the Nation needs more primary physicians and fewer specialists. We know that the mix of primary care practitioners and medical specialists in training is not consistent with perhaps even the current and clearly the future needs of our health care system.

The key objective in reforming Medicare's graduate medical education payment methods is to develop a policy which will encourage a better balance of generalists and specialists for our health care work force.

Today, Medicare pays for its share of graduate medical teaching by training at teaching hospitals, usually for training in tertiary care academic health centers. Primary care training has generally not been the principal mission of these academic health centers, and these teaching hospitals may never be the best locations to carry on such training, since many experts believe that primary care training, to a great extent, is better accomplished outside the hospital in medical offices or clinics.

At the same time, many of the services provided by our academic health centers depend on residents in specialty training. These training hospitals provide essential medical services for Medicare beneficiaries and other Americans which cannot always be easily replicated in other settings.

In addition, these institutions are responsible for significant advances for medical science and technology.

In many locations, academic health centers not only serve as regional resources for highly specialized services, such as trauma and cancer centers, burn units, and neonatal intensive care units, but also provide much of the medical care needed by the people in surrounding inner-city communities.

Many of the Nation's major teaching hospitals have historically been located in inner cities because that was where they were originally located, and the city changed around them more because they were built in certain neighborhoods specifically to serve the urban poor, which means that academic health centers are often

the major employers in those areas and the principal consumers of neighborhood goods and services as well.

Complicating the graduate medical education issue even more is that the fact that as the health care market moves toward managed care, there is a financial squeeze on such teaching hospitals, because many of the services these hospitals offer can be more cheaply provided in nonteaching settings, and so managed care plans tend to shy away from sending their insureds to these institutions.

Our efforts to encourage Medicare beneficiaries to elect this private-sector option of managed care only intensifies pressures on teaching hospitals. So we are left with the dilemma of how to redirect training programs, while preserving the best of what academic health centers offer, in addition to solving the cost and choice issues which face the Medicare problem.

I look forward to beginning our discussion of these issues today and especially on the ideas of individuals who have thought about this problem for a long time.

And with that, I would yield to the ranking member, the gentleman from California, Mr. Stark.

Mr. STARK. Mr. Chairman, thank you.

This hearing is propitious. Every list of cuts in Medicare that have been floated by the Republicans suggests that Medicare support for teaching hospitals should be slashed. We are about to slash billions and billions of dollars from children's programs to pay for tax cuts for the rich. I suppose one of the good things is that these tax cuts for the rich will inure to many of the same physicians who will be out of work when we close the centers of excellence under the Republican plan to cut a couple of hundred billion out of Medicare.

Scheduling the hearing at this point allows us to express our support for teaching hospitals and opposition to rather mindless cuts in the Medicare program without understanding how it relates to the overall medical delivery system in our country.

The issue of indirect medical education adjustment is not really about formulas or regression analyses or whether we should have 4.5 or 7.7 percent. I might add that every 1 percent we cut takes a half a billion dollars a year out of these centers of excellence. But that is not the issue.

I think the issue is, say, that a hospital is performing a mission in the inner city. It is no accident that two-thirds of our teaching hospital payments go to disproportionate share hospitals. These hospitals have the lowest margins of all hospitals. And I am not willing to attribute that to bad management or lack of entrepreneurship or lack of interest in the profit motive.

I am willing to attribute that to a mission that is humane and may not be understood by the majority, but it is a system that tries to help everybody without regard to their income.

Along with the pressure that these institutions will feel with cuts in Medicare spending, these hospitals are also under pressure due to this push toward private health plans and contracting Medicaid and Medicare to the so-called profit sector.

What health plan, what Humana, what Prudential, in its right mind, if they have one, would sign a contract with a hospital whose

costs are inflated because of the presence of large numbers of people who cannot and do not pay or who provide research in skills that the average hospital cannot?

Why should these private hospital plans contribute to the cost of training the next generation of doctors when they can get away without paying their fair share?

Our unwillingness to require private health plans to contribute to these costs, which teaching hospitals cannot avoid, may mean that the very children the Republicans are so worried about assuming the debt of future generations will wake up with no debt and no medical care either.

This does not mean that the indirect medical education adjustment or the direct graduate medical education adjustment period by Medicare cannot be changed. It should be. And we Democrats on this committee proposed such a cut last year.

The difference is, the cut was coupled with a program which assured every American health coverage, so that the debt and charity care in these safety net hospitals would have been a thing of the past.

Our bill proposed to require private health plans to contribute to a pool of funds used to support graduate medical education. The bill reduced support for nonprimary care residencies and increased support for primary care residencies.

Mr. Chairman, this approach is the right one to reducing Medicare's support for these hospitals, and is as valid today, even more valid in the absence of health reform, than it was in the previous Congress.

So I conclude with a plea, Mr. Chairman, that the debate center around these issues and the role of teaching hospitals in our health care system and the appropriate way to assure that all benefits from them should be the central question and not ways to raise money to give tax cuts to the rich.

Chairman THOMAS. I thank the gentleman.

Our first panel—and I would ask the panelists to come up—will be Dr. Shine, Dr. Heyssel, and Dr. Ludden.

And to provide an additional introduction of Dr. Heyssel, who is former president of Johns Hopkins Medical Institutions, is a fellow who is somewhat familiar with that geography, the gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

I just really wanted to welcome Dr. Heyssel to the Ways and Means Committee. I know he is not a stranger here in Washington.

We were very blessed to have Dr. Heyssel in Baltimore heading up the Johns Hopkins University Hospital for many, many years, and his visionary leadership in our State really, I think, added to the reason why Maryland was able to develop such a successful hospital reimbursement system.

He is a friend. He has helped me personally in developing my own views on health care, and it is a real pleasure to welcome him to the committee.

Dr. HEYSSEL. Thank you, Congressman Cardin.

Chairman THOMAS. Thank you, doctors, very much. And I will tell you that your written testimony will be made a part of the

record, without objection, and you may proceed in any way you see fit to inform this panel.

Let us start with Dr. Shine, and then we will move across.

STATEMENT OF KENNETH SHINE, M.D., PRESIDENT, INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES, WASHINGTON, D.C.

Dr. SHINE. Thank you, Mr. Chairman. It is a pleasure to be with you.

As I indicated in my written testimony, my experience or my comments are based on experience as a trainer of cardiologists, internists, and serving as dean and provost of a medical school.

I currently serve as president of the Institute of Medicine, but it should be clear that my comments today are personal comments, although the Institute has studied a number of these issues and concurs, for example, with the observations you have made about the importance of generalism.

I want to go directly to the principal proposal that I would like to make and to try to elucidate that in terms of the issues you raise.

I believe we should immediately place a freeze, an absolute freeze, on the total number of graduate medical education positions funded in the United States and certainly the number of those positions funded through Medicare, and hopefully, in fact, all positions. I want to try to convince you that that is a sensible thing to do.

As you have pointed out, the fundamental problem is both the question of having an adequate number of generalists versus the question of the total number of physicians, particularly subspecialists, in the country.

I believe there is evidence that market forces are working on generalism in a very effective way. Salaries for generalists are rising. As managed care increases its activities, they are, in fact, scooping up generalists to a significant degree. Salaries for subspecialists are declining. And I believe there is very good reason to be optimistic.

If you look at the data from medical students, you will find that over the last 3 years medical students who have indicated an interest in careers have gone from 14 percent of graduating students to 23 percent indicating an interest in generalism, and I think these young people are smart. They know where the jobs are going to be. They know what the market is doing. And I think they will continue to move into generalism.

The dilemma, however, is that in the absence of any limits, we keep training more and more physicians, and that surplus involves lots of people who become subspecialists for a variety of reasons.

Why will the market not work to control the total number of physicians?

It will not work for several reasons. First, because institutions, as you have heard and know, can use resident physicians to provide care. At the present time, these trainees are a subsidized form of service, and it is to the advantage of institutions to add more residents under a variety of circumstances in order to get the work

done. And so medical students and others are told that there are good opportunities in these particular areas.

Second, in the absence of any limits, the number of international medical graduates who come to this country has continued to escalate.

Now just to make this as clear as possible, between 1988 and 1994, the number of residents in graduate medical education programs increased from 84,000 to almost 104,000, 20,000 more each year. Each of those residents represents 35 to 40 years of professional service. So in terms of the health care system, we add 4,000 residents a year, which is what we have been doing; you basically are creating a cost center for 160,000 physician years.

Now one of the questions would be: Well, if the price comes down, if subspecialists charge less or receive less, why will that not ultimately decrease the supply?

Well, there are several reasons. One is that the pipeline is very long. It takes 7 to 10 years for people to prepare.

But more important, practicing in the United States is very attractive to international medical graduates, and over the same time period, the number of international medical graduates has gone from about 7,200 to over 18,500; that is, 11,300 more international medical graduates have gone into residency programs over that same period of time.

The effect, then, is that the forces are to increase the number of physicians.

Let me just conclude by arguing that if you have a cap, if you have a freeze, that it does several things for you.

First, it reduces the rate of rise of costs, because it is harder to add more people. At the present time, if an institution has an accredited program, it can add more residents.

Second, it has the effect that if one is going to have more generalist positions in your program in a particular institution and you are frozen, you have got to diminish the number of subspecialty slots.

Third, we all believe that people need to have more training at sites outside of the hospital, and we want to see the rules change so that individuals can take care of senior citizens in the community and so forth.

Right now, if you change the rules, that is dangerous, because there will be the tendency to increase the number of residency slots to provide high-tech care. In the presence of a freeze, if you had a fixed number of people, you can use them in a variety of community slots. They can do preventive care; they can work on Medicaid and managed care programs and so forth without running the risk that you will continue to escalate the number of individuals.

Let me just conclude by saying that I am concerned about the issue of payment to these institutions. As you made reference in your statement, as more and more Medicaid and managed care occurs, there is going to be less and less support for this activity.

And I do believe that if managed care organizations and other payers were required to make some contribution to medical education on a percentage basis, that that would have the effect of providing support and a level playingfield, so that one managed care organization was not giving an advantage to another by virtue of paying for some education. And I think we ought to consider that.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF KENNETH SHINE, M.D.
NATIONAL ACADEMY OF SCIENCES

Mr. Chairman, Ladies, and Gentlemen:

My name is Kenneth Shine, M.D. I currently serve as President of the Institute of Medicine (Institute) of the National Academy of Sciences. As Chief of the Cardiology Division at the UCLA School of Medicine, I was Program Director for a subspecialty training program in cardiology. As Chairman of the Department of Medicine at UCLA, I was the Program Director for training in all aspects of internal medicine, including general internal medicine. As Dean and Provost at UCLA, I was responsible for training programs in all of the medical and surgical specialties. I helped to develop an outstanding program in family medicine residency at UCLA. For many years, that program was one of the few that was physically based at the core facility of a major tertiary care academic medical center. As Clinical Professor of Medicine at Georgetown University School of Medicine, I continue to teach and see patients with interns, residents, and fellows. Although the Institute and many organizations with which I have belonged have issued a variety of statements with regard to graduate medical education, my comments this morning are my own, and I do not represent any organization or the Institute in making these remarks.

In many ways, the system of graduate medical education in the United States is the envy of the world. This is reflected, among other things, in the large and rapidly growing number of international, i.e., foreign, medical graduates who seek their training in American teaching hospitals. The funding of this program has depended critically on medical education payments through the Medicare program. Such payments have been critically important to our society in many ways. They have provided salary support to young medical graduates, many of whom now leave medical school with debts of $100,000 or more--debts that have the pernicious effect of encouraging graduates to seek careers in highly compensated and technologically driven aspects of medical care, often at the expense of the country's needs for generalist physicians. The payments allow economically disadvantaged and underrepresented individuals to obtain graduate medical training. Payments through the Medicare program have allowed hospitals to provide outstanding care to Medicare recipients, to poor and underserved populations, and to the very sick patients with complex illnesses who require all of the technological and personpower skills of these institutions.

But the reimbursement system has had a series of unintended consequences. It is these consequences that I wish to address. I shall make the following recommendations.

1) The number of graduate medical education positions funded through DME and IME money should be frozen at current levels. If possible, the total number of graduate medical education positions irregardless of funding sources should be frozen at the same time.

2) Institutions should be in a position to assign residents to activities in the outpatient or ambulatory environment at local and at distant sites, including community health centers, community-based centers for care of the elderly, managed care organizations, urban and rural locations.

3) Within the reimbursement formulas, some disincentives for subspecialty training and increasing incentives for generalist or primary care training should be included.

4) Assignments of residents should be based on the need for experiences which offer an adequate balance between generalist and subspecialty care, preventive as well as curative care services, and as part of multidisciplinary groups of health

providers, including advanced practice nurses, physician assistants, and community health workers.

5) Hospitals should be encouraged to develop alternate providers, advanced practice nurses, physician assistants, and health workers to provide service in urban municipal hospitals, rather than depend on GME to provide services.

There is increasing evidence that we are educating and training far too many physicians for our country's needs. Professor Weiner at Johns Hopkins has estimated that we will have an excess of 163,000 physicians in the period between the year 2000 and the year 2020, the vast majority of whom will be subspecialists (151,000). Evidence for the surplus of physicians is already apparent in the number of subspecialists who are currently being laid off by managed care organizations or who are being told that they must be retrained as primary care providers. In some cases, no such retraining is offered, but the effectiveness of training to turn a subspecialist into a primary care provider remains in doubt. As the efficiencies of managed care are felt, requirements for subspecialists are diminishing rapidly. In this sense, market forces are at work and, in many respects, these market forces are constructive. For example, the beginning salary for generalists is rising steeply as organizations bid for their services. In southern California, the starting salary for a general internist has risen by 35 percent to 40 percent. Similar kinds of changes have taken place around the country.

Market forces do seem to be having a significant effect upon the choices of medical students as they think about the kinds of training and careers to which they aspire. This is reflected in the increase in the number of graduating medical students who, according to the Association of American Medical Colleges, have indicated their interest generalist careers. From 14 percent of graduating students indicating a generalist interest three years ago, the number has increased to 23 percent and is likely to continue to rise as these students understand the job opportunities and income possibilities.

However, market forces alone will not solve the problem of the increasing physician surplus, and the current organizational structure of the IME and DME programs have much to do with this problem. First, the current law provides that institution may add additional residents to accredited programs largely at their own initiative. Under these circumstances, the amount of both DME and GME monies, which they receive, is increased. The effect is that public monies are used to subsidize salary and support of residents, who then provide services to patients in these institutions. Given the health care needs in large urban centers, hospitals have been rapidly adding residents. In 1988-89, there were 84,273 total number of physicians in graduate medical education in the United States. By 1993-94, the number had risen to 104,159, an increase of 20,000 physicians with an average increase of 3.9 percent per year. Since the average physician practices for 35 years to 40 years, the effect of this is to add 140,000 to 160,000 physician years of service to the nation's health care system, which are costs to be borne by the overall health care system. Even though individual compensation salaries or reimbursements may decline in response to market forces, the addition of a large number of individuals, who will be in surplus as a consequence of a cost reimbursement approach through the GME support, is illogical. Although the number of graduates of American medical schools has been relatively constant over the last decade, the number of foreign medical graduates in graduate medical education has increased from 7,227 in 1988 to 18,593 in 1994. This is an increase of approximately 11,300 physicians, accounting for approximately half of the increase in total graduate medical education positions. Which leads to the second important point. Although market forces will decrease reimbursement, so long as there are unlimited numbers of positions available, international medical graduates still will find opportunities and incomes in the United States attractive enough so that they will continue to fill this rising number of positions.

While increasing the supply of physicians has produced some marginal redistribution of physicians to smaller communities, in fact, the need for physicians in

rural communities and underserved urban communities remains very high and is not likely to be solved solely by flooding the market with physicians. Other strategies, including professional, technological, and management innovations will be required to meet these needs.

There have been many proposals by organizations to limit the number of positions under graduate medical education. The most common proposal is that they be limited to 110 percent of the number of graduates of American medical schools. Such a rule requires significant downsizing in the number of residents at the present time. I strongly urge the Congress to change legislation so that, at the very least, the total number of positions supported using Medicare monies be frozen at the current level. The effect of a freeze would stop this increase of almost four percent per year in the number of physicians added to the workforce. If an institution wished to add a resident without the use of GME funds, they could have that opportunity, although I believe an absolute freeze makes even more sense. Under a freeze, an institution could shift residency positions from program to program, and residents could be assigned to multiple non-hospital sites without increases in the total number of residents.

This leads me to the second major flaw in the current system. The formulas for reimbursement in graduate medical education lie predominantly on calculations and services related to inpatient beds. This has two effects. First, it causes institutions to keep a disproportionate number of positions in subspecialty areas employing technology on an inpatient basis. Secondly, it means that the educational experience is often disconnected from the real needs of society and of the health care system. Medical education must move increasingly into ambulatory services not only at the hospital but into the community, urban and rural, for all segments of society.

The managed care industry emphasizes that it may take them 18 months to prepare a physician, even those with generalist training, to practice appropriately in the managed care environment. We must use limited resources in health care to provide services for all elements of society, including the poor, the elderly, and the underserved, in non-hospital sites, with the extensive use of non-physician providers as part of a team that can emphasize preventive services, consult with young parents about illnesses before they make use of the much more expensive emergency room to receive needed care, and to emphasize preventive programs. Under current circumstances, institutions cannot construct educational programs for their residents based on either the long-term social or professional needs, but rather organize these programs in order to meet the requirements for reimbursement. Under circumstances of the freeze, institutions ought to be allowed to plan resident educational activities based upon educational requirements for physicians and the overall health care needs of the community in which they work. Under such circumstances, residents might spend substantial amounts of time in neighborhood health clinics rotating through managed care organizations and otherwise providing services that are the most cost-effective and useful way to improve health in the community. Under these circumstances, if an institution wished to increase the number of residency positions in the generalist or primary care specialties, it could do so but only by reducing the number of positions in the subspecialties. A freeze would then begin to ameliorate the potential long-term cost to society of producing too many physicians with public subsidy and would create a set of conditions in which the more appropriate assignment of residents, according to social and educational needs, would become rational for all concerned. Indeed, one could support the arguments previously made that the formula for reimbursement might be altered so that a higher premium is offered to institutions that substantially change the ratio of generalists to specialists. Those of us concerned about graduate medical education are also worried that residents have been added and assigned according to the work needs of the institution rather than to the education needs of a student. Under a freeze situation with some premium for generalist physicians in comparison to subspecialty physicians and increasing flexibility for educational program directors to make assignments to a variety of training sites, this goal of emphasizing education versus service would, in fact, result in better service in the right places, according to the patients needs.

Let me conclude with two other observations. First, Medicare has been a critically important source of support for graduate medical education. But all of society benefits from these education programs. The entire health care system, including managed care organizations, clearly require the workforce that is generated through these program and clearly benefit from their existence and from their quality. Creating some form of all-payor system, in which all insurers and managed care organizations, as well as Medicare and Medicaid provide a small percentage of their revenues toward education, would go far to both spreading the burden and acknowledging the responsibility of all public concerned parties. Moreover, it would deal with an important problem for academic health centers as more and more Medicare recipients are care for in managed care organizations. As this practice increases, direct medical education costs are no longer paid since these are included in the premium received by the managed care organization from Medicare. When the managed care organization negotiates with a teaching hospital, it is under no obligation nor does it ordinarily include in its rates any consideration of the training capacity. Prudent policy would, at the very least, require such organizations to include such support in proportion to their Medicare enrollees, and, as I suggested, from a public policy point of view, I believe the burden should be shared in relation to all health care coverage.

I want to emphasize the fragile nature of our academic health centers at the present time. These centers are truly gems nationally and internationally. They are the sources of the research that has fueled the biotechnology industry, the medical device industry, and many other productive elements of our society, contributing not only domestically but representing a large proportion of exports which contribute positively to the trade deficit. They are important employers and they are critically important to provide, on the one hand, the most highly specialist care for the most desperately ill in our society, and, on the other hand, a very large proportion, perhaps as much as 45 percent or 50 percent of the care to poor and underserved. As the private sector organizes more and more health care into managed care where price is the overwhelmingly important factor in negotiating contracts with academic health centers, income streams to these centers for both professional and other services are under enormous pressure. Faculties in these centers organized practice plans beginning in the early 1970s, in which they accepted the responsibility that a significant amount of the money that they earned in billing patients would not go into salaries but would support education and research. The Association of American Medical Colleges has estimated that over $800 million per year in patient care revenues goes directly to the support of research, and another $1.6 billion or more goes for the cost of education, including medical student intern residency and fellowship education. I believe that this is a gross underestimate, and that the amount of cross-subsidy from patient care may be closer to twice this amount. Whatever the figure, the development of increasing price competition is rapidly reducing the amounts available to these academic health centers for research and education. They are downsizing. They are developing a whole variety of mechanisms to accommodate to the changing health care delivery scene. But I believe all of us should be acutely aware that they are at considerable risk in this whole process for economic viability in general and, more specifically, for purposes of this hearing, they are at enormous risk when it comes to maintaining important educational programs. I believe that the investment of Medicare monies in medical education is an excellent one for our society and, if rationalized both in terms of numbers and formulas by which the reimbursement is provided, is critically important to academic health centers, their educational mission, and their capacity to provide care in their communities. In the current deficit reduction mode, I would remind you that these educational costs for Medicare represent less than a one percent investment of our trillion dollar health care enterprise. There are many opportunities for improving this system, but I urge the committee to carefully consider the potential long-term benefits to our society of obtaining more value for these funds rather than simply reducing the amounts of money available.

Thank you for allowing me to make this presentation.

Chairman THOMAS. Thank you very much, Dr. Shine.
Dr. Ludden.

STATEMENT OF JOHN M. LUDDEN, M.D., SENIOR VICE PRESIDENT FOR MEDICAL AFFAIRS, HARVARD COMMUNITY HEALTH PLAN, BOSTON, MASS.

Dr. LUDDEN. Thank you, Mr. Chairman.

I am John Ludden. I am senior vice president for medical affairs at the Harvard Community Health Plan (HCMP) where I have practiced psychiatry for more than 20 years.

HCHP, as you may know, is now a partner in what is the largest and oldest HMO in New England, a nonprofit HMO. We have just about 1 million members, and we have 16,000 physicians. And perhaps most interesting to this committee is our long-term relationship with some of the Nation's preeminent teaching hospitals at Harvard and related to Dartmouth as well as to Brown.

I would like to concentrate on about three different areas.

One, I would like to review again some of the background of the current professional education and graduate medical education from the HMO perspective, to talk a little bit about the HCHP experience as a model of a teaching HMO and to add to some of the recommendations which you have already heard for future action.

In my view, education is a classic example of a public good and not a marketplace commodity. GME, as you have stated, is necessary, so that our society can educate physicians for the future to take care of our children and grandchildren. But this marketplace is changing and has changed radically, and it calls for changes both in how we finance GME and what that GME does.

And furthermore, to add to that difficulty, I would just like to comment that changes in GME also require changes in undergraduate medical education which are more significant and, believe it or not, even more difficult to finance.

Well, as you have already heard, GME comes to us primarily through cross-subsidies from service dollars that are received by teaching institutions and physicians, and Medicare has been the main focus for that at the Federal level.

As we compete in a marketplace of HMOs in a region like New England—and I think this is true in other HMOs—we are increasingly having difficulty doing what we, as HCHP, already do on a voluntary basis, to support and finance GME.

We do not experience difficulty from our major teaching hospitals in their providing to us cost-effective and high-quality care, sometimes at underlying costs that are lower than those of some of the larger community hospitals; that is, until you add in the requirements that they face for medical education.

As you have already heard, the changes in the health care marketplace also call for changes in the supply and the skills of professionals.

Obviously you have already heard about the importance of recruiting and finding and training more generalists. What you may not have focused on yet is that physicians in the new world of health care require an expanded set of skills.

HCHP and other HMOs have found recent graduates of GME programs incompletely prepared for primary care practice. Because

of that, the medical leaders at HCHP and Group Health Association of America have focused on a new set of competencies and skills which are required, skills in cost-effective delivery, skills in interpersonal care, and especially in teamwork and obviously in providing effective care and in managing care and referrals. These are primarily skills that can be found in ambulatory settings. And we need to shift our attention away from the hospitals to such ambulatory settings.

Let me just comment very briefly on the fact that HCHP is a model of a teaching HMO. We have put money into teaching, research and community service from the very beginning of our 25-year history, including a teaching center and the first ever Department, cosponsored with Harvard Medical School, of Ambulatory Care and Prevention, which we cofund with them.

We have developed new programs in primary care education with the Brigham and Women's Hospital, sponsored primary care residencies at other Harvard-affiliated hospitals, and have sponsored a psychiatry residency program with HMS.

We are looking to do this further, and we have presently been required really by marketplace pressure to reduce our contributions, so that this year we will still be spending $2.5 million directly on programs for mostly graduate, but some undergraduate, medical education.

Let me try to skip to just four things in conclusion.

First, you have already heard of the importance of allocating financing appropriately to the sites of training, so that it can be focused on the new marketplace.

Second, HMOs and other organizations should be able to receive direct credit or reimbursement for their ongoing expenditures directly in support of medical education, including GME.

Third, you have heard about the increase necessary in primary care. I believe that financing should also be included for nonphysician primary care education.

And fourth, such GME financing should be broad-based and separate from service delivery costs, so that in this competitive marketplace we can assure that education costs are quantified, justified, and directed appropriately.

I would be glad to work further with you and answer any questions later on. Thank you.

[The prepared statement follows:]

TESTIMONY OF JOHN M. LUDDEN, M.D.
HARVARD COMMUNITY HEALTH PLAN

Introduction

Mr. Chairman and members of the Committee, I am John Ludden, MD, Senior Vice President for Medical Affairs of the Harvard Community Health Plan (HCHP). HCHP is a partner in the oldest and largest health maintenance organization (HMO) in New England. Our recent merger with Pilgrim Health Care creates a healthcare organization providing care and coverage to nearly one million members through 16,000 physicians and 110 hospitals in Massachusetts, Rhode Island, New Hampshire, Maine, and Vermont. These include some of the nation's preeminent teaching hospitals, including Brigham and Women's (Harvard), Mary Hitchcock (Dartmouth) and Rhode Island Hospital (Brown).

I am pleased to have the opportunity to testify today, and would like to:

- o review background on current issues in health professions education from the HMO perspective;
- o describe the HCHP experience as one model for a "teaching HMO;" and
- o provide recommendations for future action.

Issues

Education is a classic example of a "public good". Graduate medical education is necessary if our society is be assured that future generations of physicians will be available and skilled at providing care for us, our children, and our children's children.

But, as this committee knows, that education now takes place in a rapidly changing health care marketplace. That marketplace calls for changes in our current graduate medical education financing models, the supply and skills of physicians and other practitioners that we educate, and our educational approaches.

Financing: Graduate medical education has traditionally been financed partly through cross-subsidies from service dollars received by teaching institutions and physicians. Medicare has been the principal federal source of such financing for graduate medical education, with funds flowing to and through teaching hospitals in the form of indirect medical education (IME) and direct medical education (DME) payments.

This committee is well aware that increased competition and the rapid evolution of managed care are a significant, market-based success story in health care. HMOs like the HCHP are proud of our role in that change. But we must also recognize that our success in developing market-based competition for financing and delivering health care services has some consequences that have to be addressed. And one of them is that our current service-based mechanism for financing graduate medical education cannot survive. It is increasingly difficult for teaching institutions and physicians to pass along the extra costs of education to payors as part of their service delivery. And HMOs that presently try, on a voluntary basis, to support and finance GME face the same problem -- a competitive market that limits premium increases which are the source of financing.

Professional supply and skills needed: The changes in the health care marketplace also call for changes in the supply and skills of health professionals.

First, I would reinforce what you have undoubtedly heard from others. We need more generalist physicians -- and non physician practitioners -- who care for patients on a long-term basis with a focus on prevention and health promotion.

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Second, we need physicians with an expanded set of skills. HCHP and other HMOs have found recent graduates incompletely prepared for primary care practice. Because of this, medical leaders who are part of the Group Health Association of America (GHAA) have defined a set of core competencies for primary care physicians. Among the skills needed are:

- Skills in the cost-effective delivery of quality health care;
- Interpersonal and teamwork skills;
- The ability to provide effective care to diverse populations;
- Skills in managing care and making appropriate referrals;

Educational models and sites. Finally, the graduate medical education financing and delivery system must adapt to this new environment and produce the physicians with the skills necessary. The significant shift in services from inpatient to ambulatory settings leaves residents trained in hospitals ill-equipped to function as ambulatory care practitioners. Educational models must adapt -- with more education provided in ambulatory settings such as those available through HMOs -- and the financing models must adapt to make payments available to those sites of training.

HCHP's Commitment to GME

Since its founding in 1969, Harvard Community Health Plan has been committed to teaching and research: the HCHP corporate mission statement notes: "Our strong service program also supports teaching, research and community service."

HCHP has been a national leader in defining the role of HMOs in graduate medical education. HCHP continues its commitment to these areas through its financial support for programs designed to develop innovative methods of delivering quality care, and to training future physicians. Let me provide some examples: our growing participation in medical education led to the creation of the HCHP Teaching Center and our co-sponsorship, with Harvard Medical School, of the Department of Ambulatory Care and Prevention (DACP), the first medical school department in the country to be established and sited in an HMO. Its mission: the development of educational and research programs for preventive medicine and for the practice of medicine in the ambulatory setting.

- HCHP and the Brigham and Women's Hospital have jointly developed a new model of primary care training for the practice of adult primary care internal medicine. The program is specifically designed to allow each resident to achieve the broad competencies required for successful and satisfying primary care practice.

- For 20 years, HCHP has also sponsored primary care residency programs with the Cambridge and Mt. Auburn Hospitals, and in collaboration with four other Harvard institutions, sponsors a psychiatry residency program, which is now the largest in the United States.

- HCHP has been exploring the possibility of establishing a more comprehensive training program for primary care pediatricians interested in HMO experience, in conjunction with Children's Hospital and Boston City Hospital.

- The HCHP Foundation also funds several fellowship programs, including a mental health fellowship, which focuses on applications of brief psychotherapy in the HMO environment, and the Thomas O. Pyle Fellowship, which focuses on the appropriateness and effectiveness of medical care.

These activities have been supported through the HCHP Foundation, funded from premium revenues. It was originally intended that the HCHP Foundation would receive 1 1/2 percent of premium income, with about one-third of this percentage devoted to the development

of teaching programs. However, as I noted earlier, the market limits the ability to invite such financing, and HCHP provides such examples.

Over time the demands of the marketplace have reduced the percentage contribution to the HCHP Foundation so that it is well below one percent, with a consequent decrease in the percentage set aside for teaching. In recent years, the HCHP Foundation has received a budgeted dollar amount, adequate to maintain ongoing programs, but no longer on a percentage basis. In 1995, HCHP's Foundation expects to spend over $2.5 million on support for defined programs in medical education. These programs include graduate medical education but also include a growing commitment to undergraduate training and to innovative programs focused on the doctor/patient relationship, nursing education, and, for example, the pregnant teen violence prevention program.

But, as savings in health care costs become more and more a part of the competitive marketplace, these contributions are questioned. As the market continues to force HCHP and other managed care organizations to become even more cost competitive, the impact on programs for teaching and research will be dramatic.

Conclusions/recommendations

We seek a highly skilled workforce of health professionals for the future. If we are to produce that workforce, changes must be made in our graduate medical education programs.

Allocation of financing/site of training: GME financing should not always be directed through hospitals. Financing should follow the resident and support clinical education and training in hospital and non-hospital sites, especially including ambulatory care sites. HMOs and other organizations should receive direct credit or reimbursement for ongoing expenditures that directly support medical education, especially including GME.

The proportion of training slots for primary care should be increased: To improve the imbalance between specialists and primary care providers, an adequate number of residency slots must be in primary care.

Financing should be designated for non-physician primary care: The HMO community recognizes the importance of non-physician practitioners in the provision of primary care, and believes that some GME funds should be designated to finance the education and training of such practitioners.

Long-term, financing should be broad-based: Financing for graduate medical education must ultimately be broad-based, and separated from the service delivery costs. Such a separate financing system is required by the increasingly competitive marketplace, and necessary to assure that education costs are quantified and justified.

Mr. Chairman, I would be pleased to work with the committee and its staff as you develop proposals for changes in financing health professions education, and to answer any questions that you may have at this time.

Chairman THOMAS. Thank you very much, Dr. Ludden.
Dr. Heyssel.

STATEMENT OF ROBERT M. HEYSSEL, M.D., SEAFORD, DEL., FORMER PRESIDENT, JOHNS HOPKINS HEALTH SYSTEM

Dr. HEYSSEL. Mr. Chairman, Congressmen, ladies and gentlemen, I am Robert Heyssel. I was for 20 years president and CEO of the Johns Hopkins Health System.

Chairman THOMAS. Doctor, I would tell you that the microphones are very unidirectional, so you need to get right in front of it.

Dr. HEYSSEL. OK, thank you.

In Baltimore, Md. I thank you for the opportunity to give my view on graduate medical education.

In the mideighties, I chaired a task force funded by the Commonwealth Fund of New York, looking into and examining the health and the future of the academic health centers. Then as now, our concern was the maintenance of the mission of education, both undergraduate and graduate, and patient care and discovery in those institutions, which I believe are the best in the world and really the basis for our excellent medical care in this country.

A prominent part of that report, which was called "A Prescription for Change," dealt with issues surrounding graduate medical education. In preparation for this testimony, I looked at that again, and there is very little that I would change, either in terms of the findings or the recommendations with regard to graduate medical education.

That was published in 1985, and not much has happened since then.

There were a number of issues identified then which are with us now. The first issue is cost and how those costs are paid.

Most of the direct and indirect payments for resident education is from hospitals themselves, which in turn add those costs to inpatient bills, Medicare, and where they can, private payers as well. That source of payment is in jeopardy from both government payers and private insurers, as all payers seek lower cost hospitalizations and alternatives to hospital care. This is particularly true of managed care organizations in this country.

Second is the issue of size and specialty distribution in graduate medical education. As managed care becomes a dominant means of financing and controlling the costs of medical care, we are probably producing more physicians than the country will need, fewer generalists, and more specialists and subspecialists of certain kinds than we need.

Third is the issue of the control of graduate medical education. As amply documented in the 1985 report, which incidentally I have asked the staff to make available those portions of the report related to graduate medical education, the control of funding of graduate medical education is separate from the control of the length of the training programs, the content of those training programs, and requirements for accreditation of programs, all of which are set by RRCs and the Accreditation Council on Graduate Medical Education.

This, in effect, controls the costs, the ultimate costs. And they have no responsibility for the costs or getting the funding. That is left to the hospitals.

The issue of sites of education and educational support is also entwined in that. As more graduate medical education is conducted in outpatient settings, as is necessary if we are going to emphasize primary care, payment through hospitals as the primary source needs reexamination. In effect, I think we need to form some consortia between those organizations involved in outpatient care as well as the hospitals.

Funding, then, should be broadened. All payers should contribute to a pool for GME. They, after all, also profit from GME. The training of generalists, as noted earlier, is terribly important to managed care organizations as well. So there should be a pool from all premiums or other sources, as well as from Medicare and Medicaid.

There should not be an attempt, in my judgment, to set numbers of trainees by specialty, specified sites where training is conducted, or the mix of specialties in those sites. I think consortia, as I noted, should be encouraged. I think the marketplace is beginning to have a real effect on career choices of physicians, as was noted earlier, and will in the future.

Support should be assured for 3 years of graduate medical education, essentially the length of time for accreditation in primary care specialties. Certain programs, such as general surgery, may require longer than that and should be supported to first accreditation. And I think really support to first accreditation should be the general rule.

For specialties or subspecialties requiring longer, I would suggest that support would have to be found either from the individuals themselves, which was true in the past, professional fees of sponsoring training programs, private scholarships, or other sources.

And then finally support should be limited to the number of graduates in any given year from accredited medical schools in the United States.

There are many details behind my comments, but I will be glad to answer any questions. Thank you.

Chairman THOMAS. I want to thank all of you for your succinct statements, and obviously there are going to be a series of questions from us. And we will start with the gentlewoman from Connecticut.

Mrs. JOHNSON OF CONNECTICUT. I think your recommendation that we should limit the number trained is a very interesting one.

Within that envelope, how has this issue of specialists versus generalists been working out?

I read something recently that indicated that the majority of medical students now are looking for residencies in some kind of family care environment or are interested in that specialty.

Is that true? In other words, is the problem of too many specialists and not enough generalists being addressed in the real world out there?

Dr. SHINE. There are two answers to that. First in terms of the percentage, this year, for example, approximately half of graduating medical students selected residencies in areas which we would call general areas. In fact, there will be attrition, because a certain

number of those, even though they started in internal medicine, will end up as subspecialists, and it is more likely that you will be looking at something in the range of 30 to 35 percent of those people ultimately remaining in a generalist or a primary care environment.

Mrs. JOHNSON OF CONNECTICUT. Is that higher than 5 years ago?

Dr. SHINE. Yes. And that is the reason that I made the point that I think the trends in terms of the distribution are in the right direction.

The dilemma, from my perspective, is that the absolute number continues to rise so rapidly that even though you increase the proportion who become generalists, the absolute number of subspecialists just continues to skyrocket.

Mrs. JOHNSON OF CONNECTICUT. Well, we looked at this issue in the last Congress. One of the suggestions was for the government to determine how many in each area should be trained.

I am very uncomfortable with that, and I am interested in how rapidly you sense the market is redirecting our resources.

I am far more comfortable with the limit on the total number. And I think that is interesting in the context of Dr. Heyssel's comment that we should not reimburse for foreign medical education.

Do we subsidize foreign medical students in our system to the same degree that we subsidize citizen education in our system?

Dr. SHINE. We do not subsidize at a Federal level the medical students. It is the fact that foreign medical graduates, international medical graduates, who enter our teaching hospitals, in fact, get treated the same way as Americans.

I would emphasize that I agree with you about micromanaging the work force. One of the reasons why I am enthusiastic about an absolute cap is it still leaves within the various organizations the flexibility to decide how they are going to do the distribution. It lets market forces work, but it stops the notion that we are going to have a lot of very good, talented young people who spend long periods of time in training who are not going to have work. People whose training is being heavily subsidized, as your comments suggest, by the States, by the medical schools, by the universities and by the Federal Government.

That is not a good investment of our resources if, in fact, they are going to be largely underused subspecialists.

Dr. HEYSSEL. I would comment, I think in that regard that one of the reasons it is important to limit the length of time that you are going to support to first accreditation is that right now the penalty for spending 8, 9 years or going onto a subspecialty career in internal medicine is just not there.

There is obviously a lost opportunity cost, but it is relatively small, and it is fairly easy to go on and get the training as a subspecialist.

Mrs. JOHNSON OF CONNECTICUT. We now subsidize medical education through Medicare. Should the subsidy situation be different for foreign students being trained in our system than for citizens being trained in our system?

Dr. SHINE. That is going to be hard to do.

Mrs. JOHNSON OF CONNECTICUT. What I am thinking of is, every State university charges out-of-State students more than they charge in-State students.

Dr. SHINE. I understand that. The dilemma is a certain number of those international medical graduates are Americans who went overseas and are coming back. And the question is again: Does the fact that they got their education overseas mean that they should——

Mrs. JOHNSON OF CONNECTICUT. Well, I am looking at really noncitizen/citizen——

Dr. SHINE. And then there is a separate question of the noncitizen. And the dilemma there is that in many parts of the country, those people are, in fact, providing care during their training which is considered very critical.

And second, there are some extraordinarily talented people who come that way.

Mrs. JOHNSON OF CONNECTICUT. But they are talented. It is also a way of exporting a phenomenal level of achievement in American medicine which is important. There ought to be concern among Americans to be willing to train foreign medical personnel.

Dr. SHINE. Right.

Mrs. JOHNSON OF CONNECTICUT. But I do think we need to look to foreign governments for some of the kind of support that our government provides to the medical training setting for foreign students from countries that can afford it. I mean, it is one possible way of looking at this. I just thought I would get your thoughts on it.

Then the last question I wanted to ask, because my time has expired, this specific issue about having the right to move residents through outpatient and ambulatory environments: Are you prohibited by Federal law, by Federal regulation, by tradition of accreditors—what prevents you now from having residents rotate through those kinds of settings?

Dr. SHINE. The rules with regard to reimbursement are based primarily on ratios that are connected to beds and which limit the amount of time that the people can spend offsite.

Mrs. JOHNSON OF CONNECTICUT. OK, thank you. That helps.

Chairman THOMAS. The gentlewoman's time has expired.

The gentleman from California, Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

Dr. Ludden, in your testimony, you indicate that HMOs have a great success story, and I suspect that if you live in the Boston or Cambridge area or if you live in the East Bay of San Francisco area where you either have your institution or Kaiser Permanente, that is true.

But if you live in Florida where you have IMC or Southern California where you have had Paracelsus, the HMO managed care community has some warts and marks that they might like to live down. If they were all as good as your institution, we would have a simpler problem.

But you have been—and you are today complaining a little in your testimony about the fact, as I read it, that we pass money through in graduate medical education, and you somehow have to

pay this out of your pot, and because your competitors do not, you are at a disadvantage.

Am I reading what you are saying right?

Dr. LUDDEN. Yes.

Mr. STARK. But I think you are wrong. You are a recipient of a block grant, and that is a term you are going to hear more of, unfortunately.

In the adjusted average per capita cost (AAPCC) you actually receive funds the same as other institutions, because the way in which we reimburse you through Medicare, we lump in your share of the graduate medical education or indirect medical education, so you are really receiving it in your capitated payments.

Now it may not be enough and you may wish it were more, but the fact is, that is how the system is designed. And I just suggest that we maybe ought to change that system for how we reimburse managed care under Medicare, but I do not think that it is fair to say that you are not getting the funds.

And I am also concerned that HMOs have to avoid contracts with teaching hospitals, do they not? They cannot afford them.

Dr. LUDDEN. Have to avoid them?

Mr. STARK. Have to avoid them, sure, or price them so low that basically you will not be very attractive.

Why would you ship out, if you were a Kaiser Permanente—I do not know enough about where you would ship—why would you contract with Stanford or UC-San Francisco?

Dr. LUDDEN. We have—Harvard Community Health Plan has extensive contracts—in fact, 30 percent roughly of the Brigham and Women's Hospital is filled with Harvard Community Health Plan patients every day.

Mr. STARK. You have a unique relationship there. But do you send any to Johns Hopkins?

Dr. HEYSSEL. They should.

Mr. STARK. Of course, they should. We know that, do we not. [Laughter.]

Mr. Cardin has informed me of that. But my point is, it does seem to me that the stand-alone HMOs, Kaiser, cannot afford to deal with Stanford, and in their minds, and I think rightfully so, they do not think they have to. They have a broad range of staff, of specialists. And that does not help Stanford very much. As the HMOs grow in our area, there are fewer and fewer, as they get bigger and afford more comprehensive staffs, who want to go there and pay the higher rates that the teaching hospitals, out of necessity, have had to charge.

How do we solve that?

Dr. LUDDEN. Well, I think a number of us were talking about this requirement for really broadbased financing of GME; that is, broader than simply even Medicare, but broadly across the population, so that we can separate out the public good educational requirements from the service requirements.

As I tried to say, Brigham and Women's can compete very well on quality and cost alone, as long as you take out the requirement that they also provide all sorts of education in the middle of it.

Mr. STARK. Doctor—if I may, Mr. Chairman, just as I finish—you are preaching to the choir.

It has long been a mystery to me as to how Medicare got stuck with supporting graduate medical education. It was an afterthought, as near as I can read, in the legislative history in 1965. But the fact is, we have.

And the idea that the cost, whatever that is, ought to be—for the benefit that the public derives, ought to be spread more fairly across the spectrum, I agree with you.

I am not sure politically we would be able to do that. I mean, we have a structure that is so historic—even with the new Contract With America, I do not think we are going to be able to change that, so we are going to fuss with it and adjust it. And maybe we can do that slowly. So I think in the short time—5, 10 years—we are still going to have to find a way to subsidize, support, reimburse under the structure we have.

Could we erase it and start over?

I would agree with you. But I am afraid that we are locked into this, and we have to worry now about cutting too much out, so that Dr. Heyssel's alma mater can continue to survive.

Dr. SHINE. Mr. Stark, I would just point out that that association with Medicare does provide an opportunity, that as risk-based managed care develops for Medicare patients, looking at the way in which those organizations which choose to take care of Medicare patients, choose to support graduate medical education, is one of the things that I think the committee could look at very carefully.

Chairman THOMAS. The gentleman's time has expired. The gentleman from Louisiana, Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, gentlemen, for testifying today.

Dr. Shine, I am intrigued by your recommendation to freeze all positions in graduate medical education.

When I am home in Louisiana in my town meetings and the issue of health care and rising health care costs come up, I often have one or two lawyers in the audience, and they will stand up and say: You know, the answer to the problem here is to quit restricting admission to medical schools, and you need more doctors. If you had more doctors out there, there would be more competition, and you would get prices down and costs down.

How do I answer them, and how does that gibe with your recommendation?

Dr. SHINE. I think there are three or four answers.

First, both the State and the government do not make the kind of investment in the education of a lawyer that it does in the education of a physician.

Mr. MCCRERY. Thank goodness.

Dr. SHINE. Second, by virtue of the subsidy, if you will, for education that comes through Medicare, we are using public dollars in order to influence the work force. And the question then becomes: Is the outcome one that you want?

Third, medical providers are, in and of themselves, cost generators. Whether you are in managed care or any other area, the fact is that the more doctors you have, the more services are provided by doctors, and they are the most expensive.

The issue from my perspective in this regard is: How do you move the system so that, in fact, we are using a spectrum of pro-

viders, including advance practice nurses, physician's assistants, and others who are much more cost effective? That happens because you educate in a different environment, not because you educate more.

And finally, in spite of this incredible increase that has been going on for the last decade or decade and a half, the supply issue alone has not solved the problem of more doctors in urban America or more doctors in rural America. I would suggest to you that is not a numbers issue; that is an organizational and a management issue. We are going to have to change the way we think about health care in rural Louisiana, whether we are talking about the use of teams of providers, managed care organizations that have responsibilities in rural areas, the role of telemedicine.

There are a whole variety of issues. And I think the notion that we are going to solve that by saturating the market has not turned out to be true and will not be true if we just continue in the direction we are going.

Mr. MCCRERY. Well, I appreciate that answer, and I would like to discuss it some more at a later date.

But it sounds to me as if one of the problems is government got involved in the business and started directing resources in certain ways and produced results that are not necessarily those that were intended.

And I find that—and I do not know nearly as much about the health care system as I need to, but the more I get into it and the more I see Federal dollars being spent, the more I see consequences and results that are driven by dollars, Federal dollars, more than they are by the needs of the communities, the needs of the health care system. I am wondering if maybe we ought to examine or reexamine the whole role of government generally in the health care system and in medical education, because it does seem to be driving the system more than it is helping society.

Since you mentioned rural health care and HMOs in the context of graduate medical education, what is the role of managed care in medical education?

Dr. SHINE. I think there is a potentially large role. You heard about one program which actually is quite good, but there are others around the country.

One of the reasons that I think that managed care organizations would, in fact, be willing to contribute to the education costs is that, as you have heard, our current system does not educate individuals in managed care environments, and therefore they are not ready to go to work in those environments when they finish their training.

It would be in the economic interest of Harvard Community Health Plan or Kaiser to have those individuals, and therefore there is an opportunity for those individuals to get more training in those managed care environments.

That is beginning to happen. It is costly, because outpatient education is costly. It is much less efficient to see a single patient in the outpatient than it is in a hospital with a whole bunch of patients.

I would like to comment that I understand the issue of unintended consequences. I used that term in my paper, because what you have described is, in fact, unintended consequences.

I would emphasize, however, that these institutions are very fragile. Right now, we know that they receive somewhere on the order of $2.5 to, I think, closer to $4.5 billion in moneys that come from the practice of their faculties. And those faculties agreed 15 years ago to use a certain amount of that money to do research and to teach. Probably two-thirds of that money that they earn net goes into teaching.

As managed care organizations put the squeeze on academic health centers and those patient revenues fall away, there is going to be not only the problem of what they will pay, but the fact that faculties cannot earn enough money to subsidize the education. That is why these GME moneys are absolutely critical.

My view is not whether they should be spent, but do you spend them in the way that is the most sensible as far as our society is concerned.

Mr. MCCRERY. Thank you.

Chairman THOMAS. The gentleman's time has expired. The gentleman from Maryland, Mr. Cardin.

Mr. CARDIN. First, let me thank the Chairman for holding these hearings. I think they are extremely important and that the future of the academic medical center is indeed somewhat suspect today in the new competitive environment. We need to look at different ways of reimbursing for graduate medical education. Medicare no longer will be able to foot the full bill, and the marketplace is not capable of dealing with these issues. And I compliment all of your testimonies today.

However, it seems to me that you have acknowledged half that problem, and that is that the marketplace does not work as far as a financing mechanism for graduate medical education and that we need a broad-based financial source. I agree with that.

In the bill that we were working on last year, we looked at a way in which all health care plans, not just Medicare but all health care plans, including the self-insured plans and the private insurance plans, contribute to graduate medical education. We then pulled these costs out of the rate base, so that all health centers could fairly compete within the new market.

But on the other side of the equation as to how the graduate medical education dollars should be used as far as training professionals for health services, there seems to be no agreement, and some disagreement, as to what role government should play in order to make sure that we have more people trained in primary health care.

Dr. Shine, I am not that impressed by the increase to 23 percent of medical graduates going into primary health care. The information that we have seen is that we need probably 50 percent. It is going to take a decade before we get the results of the people entering medical training today in the workplace.

And as all of you pointed out, we need to look beyond just physician training, and toward training of other health care professionals in primary health care.

My question is, if the Federal Government establishes the financial wherewithal so that GME can be pulled out of the burdens of the health centers in their rate setting, so they can use it through a pooled source, do we not have a responsibility at the national level to make sure that the training dollars are, in fact, spent to train more people in primary health care?

Dr. HEYSSEL. If I could speak to that, Congressman, I have a problem with setting absolute numerical limits on anything in a profession which is so dynamic and is changing so rapidly over time and where there are new entrants into the field in the sense of providing primary care.

I do not know whether the number is 50 percent or not, who should be generalists, or whether it is 40 percent or whether it is 70 percent in the long haul. And I do not think that any of us could make that judgment with a great deal of certainty.

I remember when I first started at Hopkins, the Federal Government had special programs to train psychiatrists and radiologists because there was a shortage. It is the Federal Government who decided that there is a physician shortage in the late sixties and led to 15 more medical schools.

So I do not know how in a dynamic, changing society you can make those judgments, and I think that the marketplace that is now occurring, plus limiting the amount that you are going to pay and the length of time you are going to pay, will, in itself, begin to take care of the problem.

Mr. CARDIN. I agree with you that I do not know what the exact number is. I disagree in that I do not believe the marketplace will be the best barometer of who should be trained. If history is any lesson to the future, we have encouraged the training of more costly health care professionals, and each one of these individuals have been able to make a comfortable living under the current system.

Dr. HEYSSEL. Congressman, part of that is the absolute distortion in the fee schedules. You know, not all people are really after money. But if you come out of medical school with a significant amount of debt, and you can make significantly more as a procedural cardiologist or as an ophthalmologist or some other thing rather than as a pediatrician, that is going to drive you a little bit in those directions.

Mr. CARDIN. No question.

Dr. HEYSSEL. And if we change some of the incentives that drive people to do those things, I think you would change very rapidly how people behave in terms of entering the profession and doing what they are doing.

Mr. CARDIN. And we have tried that. You have made some of those changes.

Dr. SHINE. But, Mr. Cardin, if I could just comment, in 1978 the institute issued a report recommending 50/50. So I come from a position where 50/50 made sense.

The fact of the matter is, first it is clear that managed care organizations use far fewer physicians, so that if you do the calculations, the number of generalists we require in an absolute sense is not 50 percent of the current work force, because, in fact, what is happening is, their ratios are such that without much of an increase—with some increase, but with nowhere near the kind of in-

crease that you and I thought needed to be present, they, in fact, are going to come close to having the work force they need in terms of generalists.

The dilemma is the fact that the subspecialists begin to grow. And I would just remind you that in Southern California last year at UC-San Diego they hired a cardiologist for $70,000 a year, a gastroenterologist for $72,000 a year, and a general internist for $110,000 a year.

Now I believe my medical students—and I still teach at Georgetown—are smart enough to know that. And I am less worried about the ratio, although again the institute waved that flag going back to 1978. I am much less worried about the ratio now as I am about this enormous surplus of subspecialists.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman.

I come from a little bit of a different background, and so I would like to inquire just to try to learn this. I am a veterinarian by profession, and we work a little differently. The teaching hospitals do get some governmental subsidies, but I do not think in the same way that the practice of human medicine does.

For example, a specialist in veterinary medicine actually makes less than a general practitioner. But yet we still get the best and the brightest who want to be specialists simply because of the love of doing surgery, orthopedic surgery, ophthalmology, whatever it is.

Using that as a backdrop, I just wanted to say that from my experience, residents and interns were slave labor. I mean, my year as an intern, I made $14,000 a year and worked 80 to 100 hours a week, the equivalent of less than $3 an hour.

As I recall, the institutions loved us because the more interns, or more residents, they had, the better they did, because we were very cost effective.

I do not understand why it costs more money per resident on their education.

Do you understand my question?

Dr. SHINE. I am not sure. The fact is that there are a significant number of institutions in the United States which are using residents in a way that is better than it was 15 years ago, but is not inconsistent with the role you described for residents during your training.

That is the wrong reason for having residency programs. Residency programs should be first educational and second, they should prepare people for the kind of practice that they are going to need to use. And that means how do you help elderly people learn to stay in their home, rather than take care of them in the intensive care unit.

So I think what we are saying is that the kinds of changes we want to see happen are ones which have less to do with the acute day-to-day needs of the hospitals where the training goes on and more to do with providing care outside of the hospital, providing care for underserved populations and underserved areas and doing it in a way that is sensible in terms of the long term.

As far as the subspecialist is concerned, what I am concerned about is that we are already seeing underemployed and unem-

ployed subspecialists. We had a recent situation in which several managed care organizations laid off large numbers of subspecialists.

To have a system where you were trained as a subspecialist in veterinary medicine and then find there is not any work, it seems to me, is a tragic misuse of public resources in terms of what the future holds.

Dr. HEYSSEL. If I could comment, that is the reason to limit again the amount of length of time and support you are going to give as well as limiting the number of slots you are going to fund from whatever pool you get it from.

But I also cannot help but remark Dr. Shine, when you said the Institute of Medicine liked the 50/50 ratio, it was also the Institute of Medicine and the committee that I served on that said we need 4 beds per 1,000 population in this country in the seventies, which number seems a little offbase today given the changes.

Dr. SHINE. We guessed the direction but not the velocity.

Dr. HEYSSEL. That is right. [Laughter.]

Dr. LUDDEN. I just want to make the point that the HMO primary care practice frontline, it has to do with the skills and training, not the number of procedures or the number of services that can be done by something which maybe used to be slave labor but certainly is not now.

And that is a terribly important change in the way all of these developments work, so that we concentrate more on putting together those skills. And that really is a different world than it used to be 5 or 10 years ago.

Mr. ENSIGN. Right. Well, during residencies, your pay is very, very low compared to what your services are worth, maybe not at the beginning, but at least your latter couple years of your residency.

But it was looked at as a tradeoff, that you are getting that experience, and you are providing a very valuable service, and you are learning. That is the reason that you are exposed to the specialists and the senior specialists, and that was a tradeoff in the residencies.

I guess my whole question about this is, is it necessary to subsidize number of spots, and how do you do that across the country? Who gets what spots where?

Dr. HEYSSEL. Well, that has always been the dilemma. I guess you could do it at the Federal level and apportion it some way. You could do it at the State level and apportion it some way. And that always seemed to me to get us into the problem of—what should I say—indirect control of who got the slot preferences and so forth.

The other way you could do it is, we know how many medical students are graduating every year, and we know how many years we are willing to support their training after that in graduate medical education. Why not give them a voucher that goes with the student from this pool of money and let them apply wherever they would?

Dr. SHINE. Could I just point out, in terms of my proposal to freeze, I am talking about freezing in place; those institutions would have the same number of physicians as an institution that they have now. But if they want to add generalist positions—and

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many will, because they want to do more managed care and Medicaid managed care—they would have to subtract them from their subspecialty slots.

If they downsize, the total number of residency slots in an institution was diminished, you would diminish the total pool. You would not necessarily go and let somebody start a new program.

Chairman THOMAS. Does the gentleman from Illinois wish to inquire?

Mr. CRANE. Thank you, Mr. Chairman.

Dr. Ludden, in your conclusions and recommendations, you point out that graduate medical education financing should not always be directed through hospitals, and you go on to state that HMOs and other organizations should receive direct credit or reimbursement for ongoing expenditures that directly support medical education, especially including GME.

Do you think that Medicare should pay any of these entities?

Dr. LUDDEN. I think that however—I mean, we do get payment from Medicare for those patients that we have. What we need to be able to do is to focus our resources and use them in an innovative way directly in medical education as such.

With the money that we have been able to put together over the years, we have been able to affect the training programs of the Harvard and other related institutions in a positive way toward establishing more primary care and making the skills something which are more nearly what we are going to need in the future, so that it has to do with being clear on the spending side that HMOs and managed care need to have the opportunity to effect that change at the local level to make sure we get the right skills.

On the revenue side, which is a lot of what our discussion has been about so far, I would favor a more broad-based approach to financing.

Mr. CRANE. Dr. Heyssel, Dr. Shine, do you share the same view?

Dr. HEYSSEL. The view of a broad-based approach to support and that the money should be able to go to a different entity than a hospital? Yes, I do.

I would think that since hospitals are needed for treatment as well as ambulatory care sites, that an organization that was primarily involved in ambulatory care and a hospital could form a consortium around that, where the money went to that consortium rather than to the hospital alone.

Dr. SHINE. My view is that there is merit to moving it away from payment supply to the hospitals. I would recommend that it be the educational institutions that are responsible for education of trainees, and they ought to be in a position to determine the kinds of sites, the contents of the education that is required, and they would then be able to reimburse the players in the consortium.

In other words, what I am concerned about is that there are obvious exceptions, depending upon locality, but I am concerned that, "a consortium" as to have some kind of a lead agent which is responsible for how the money is used, and I would suggest that it should be the nursing school, the dental school, the medical school, whichever is responsible.

Dr. HEYSSEL. I think there is a problem with that in the sense that the residency review committees and others are, in fact, the

ones who set the content of the curriculum, not the medical schools, which I think is what Dr. Shine is referring to.

And I see no real problem with money going to a consortium that is properly put together. My presumption is it would have to have a board; it would have to have votes; it would probably have to have a corporate structure of some sort that could receive funds.

So I see no problem with controlling either sites or the content under that sort of structure with proper approaches. Medical schools should be a part of that certainly.

Mr. CRANE. Thank you very much.

Chairman THOMAS. Does the gentleman from Texas wish to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

You all intrigue me with your differences, and I am amazed that you feel the same way I do. It appears to me from what you are saying, that you are saying there are too many doctors right now. Is that true or false?

Dr. SHINE. I think we are at that point, and all of the signs are that that surplus is going to increase.

Mr. JOHNSON. Then do you think we still need 229 major teaching hospitals in this country? Anybody.

Dr. HEYSSEL. Well, I think 229 major teaching hospitals probably overstates it somewhat, since the really primary affiliated teaching hospitals in the United States number something around 115 to 130, I would guess, and then many others have smaller teaching programs.

I think the question is whether we need to be training as many people as we do rather than how many hospitals we have doing it, number one, and, number two, the question of where the sites of training really ought to be. And I repeat what I have said before: I think those sites of training need to be broadened considerably away from the hospital both for educational reasons and other reasons.

Mr. JOHNSON. Do you think that some of these mobile hospital units that are now being tested in the Southwest could provide some training capability as well?

Dr. HEYSSEL. I think that training can occur wherever there is good medicine practiced.

Mr. JOHNSON. Wherever. Especially with the ability to hook up via satellite with a good doctor somewhere, it would seem to me that we could make use of the really good guys in our country to help train all our doctors.

But it appears to me that—go ahead; excuse me.

Dr. SHINE. One, as far as the number of hospitals is concerned, the market is going to do a lot with regard to that. I mean, the hospitals are consolidating. A lot of those hospitals ——

Mr. JOHNSON. Well, it will and it will not. Does it not depend upon the educational institution involved?

I know the University of Texas, for example, does not want to give up their two medical centers.

Dr. HEYSSEL. I would bet not.

Dr. SHINE. The point is that out of that 229, I mean, we have already begun to see consolidations. We have seen it with the Med-

ical College of Pennsylvania and Hahnemann. We are seeing new configurations taking place.

I think there is going to be a lot of pressure. And I do not know what the number is going to be. It is hard for me to predict that. There are going to be both political and economic forces that influence it.

But as Bob says, the issue from our perspective is how do you get good training. If that is in a mobile unit, if it is a rural system, if it is telemedicine, that is fine.

The one thing I want to emphasize, though, is that it is not necessarily all going to be physician dependent—that is, when you talk about rural sites, when you talk about urban sites, as well as the rest of the system, managed care has learned to use a variety of other providers—nurses, physician's assistants, community health workers—and we have got to get away from the notion that everything is going to have to be done by the doctor.

And second, we have got to have an educational system in which young people learn how to work with those various players in a collegial way, how to interact with them and provide care.

And I think one of my concerns, which may be an implication of your question or an inference of your question, is that while it is true that I would like to have doctors learn from those mobile units, I do not believe we are going to solve the Nation's health problems on the basis of trying to maintain every local site as a—

Mr. JOHNSON. Well, now you have gotten to the good issue. Why is Medicare paying for medical education? See, that is the real issue. Tell me the answer.

Dr. SHINE. I think that it is very clear that it is in the public interest to prepare young people appropriately for careers in medicine and that—

Mr. JOHNSON. But think about Medicare. What is the Medicare system for?

Dr. SHINE. It is for taking care of elderly patients.

Mr. JOHNSON. So we should train young people to take care of young people, so the elderly can have medical care; is that true?

Dr. SHINE. No. What we need to do is to train young people who, in fact, will be prepared properly to take care of elderly people. And second, we need to do that under circumstances in which they are being trained in facilities and in locations, both urban and rural, in which they are able to take care of disadvantaged people, people who cannot travel, people who have a variety of other medical difficulties.

Mr. JOHNSON. Right.

Dr. SHINE. And that is what we are——

Mr. JOHNSON. And in addition—excuse me—the gentleman over here indicated there was some indecision or lack of precise designation by a unit here in Washington, for example, your institute, the National Academy, I do not believe that any one person in Washington or anywhere else can dictate what is going to happen.

All of you seem to say that the system will take care of itself, if you let it. It will sink or rise, whatever is needed. Is that true?

Dr. HEYSSEL. I think it will if the incentives are right. I think Dr. Shine is absolutely right. How many teaching hospitals we are going to have and how big or large they are going to be 10 years

from now, I think is an absolute unknown, because clearly patient care is shifting out of the hospital. It is shifting to simpler sites. And there will be consolidations; they are occurring in many parts of the country now.

So I agree with the point; I do not think in a dynamic situation you can predict absolutely.

Mr. JOHNSON. Thank you very much. I appreciate your straightforwardness.

Thank you, Mr. Chairman.

Chairman THOMAS. Questions? Let me try to pull this together. I have a series of questions to ask.

Dr. Shine, I am really at this point not worried about unintended consequences. My problem is that looking at the current picture, one, in terms of the profile of medical graduate training and where they are and who they are and how it is financed, that we have got a big enough problem with all of the knowledge that we have without worrying about the unintended consequences.

For example, the gentlewoman from Connecticut was concerned about the foreign medical graduates, and you correctly indicated that a number of them are Americans who got their medical training overseas.

We also have the foreign-born medical graduates. And if we begin to deal with that in terms of a limitation, you pretty well can write New York City off the map, since about 30 percent of the graduate medical students in New York fit the profile of either foreign medical graduate or foreign-born medical graduate.

In addition to that, I agree totally with my colleagues who have said that it does not make a whole lot of sense to fund graduate medical education solely out of Medicare, especially when you rely so heavily on the hospital portion, which is a diminishing institution, relatively still significant but relative to the other changes.

So when we are sitting here trying to figure out a way in which we accomplish a clearly desirable societal role—that is, the training of medical students—how do we create or recreate a funding structure that does not put government, as the gentleman from Louisiana said, in the role of determining who gets it, and where they get it. You know, it is almost like an industrial policy for medical education.

I am trying to figure out a way to deal with it.

You folks have offered a couple of solutions, and I want to ask the relative importance of the options as you have presented them to guide us.

Notwithstanding our desire to come up with a completely different way in which we fund—let us just assume we are going to be living with what we have got and we can tweak it a little bit—I understand the direct medical support. I do not fully understand the indirect medical support, except it is another way to get money based upon the patient profiles, and I understand the caseload and the way in which you get disproportionate share because of where you are.

If we could say that Medicare—if we did not change anything else, but we just said Medicare was only going to fund the 3 years, and that is all that Medicare is going to fund—are we a big enough gorilla to drive the structure so that you would then, by virtue of

only funding the 3 years, positively shape the mix in medical education?

Dr. SHINE. I am going to let Bob comment on that.

Could I just, Bob, say that the proposal I made for a freeze——

Chairman THOMAS. Well, I want to get to that.

Dr. SHINE. [continuing]. Deals with the New York situation. I am not proposing downsizing.

Chairman THOMAS. No, I understand that.

Dr. SHINE. But what I am suggesting is—and I think you could be creative; you could have a situation in which you have a freeze, that you provide a certain amount of GME money, and that New York City, for example, to the extent that those institutions began to develop training programs for nonphysician providers in those hospitals, may not lose the money; that is, that there be some reward to them for making those transitions rather than—as you know, they have added 3,000 to 4,000 residents in New York City over a short period of time.

So I think—I am very sensitive to that, and that is why you did not hear a proposal from me about limiting foreign medical graduates at all.

Chairman THOMAS. I understand that. But I have a multiple problem in the area that you discussed, and that is the way in which medical schools and the teaching hospitals operate, that notwithstanding the economics driving folks to pick particular positions, in many situations, given the profile of the patients and the very location of the teaching hospitals and the significant medical and technical aspects involved there, it is a little bit like folks going to college and wanting to take a particular course but finding out it is closed, and there are openings in other areas, and frankly you take what is available.

And many times because of the type of programs and locations of teaching hospitals, you inevitably wind up producing a profile which is not the most desirable. And then you say: We also want these same structures in these same locations to carry out the health care professional training of nondoctors in a context of more and more managed care, where frankly a lot of the training is more interpersonal in administrative skills along with working along with nondoctor health professionals in locations that are not traditional hospitals.

You cannot do that with where they are and the profile of the patients that they have. I agree with the idea of a freezing. I want to pursue the idea of a 3-year limitation. And clearly we want to release the money and figure out a way in which it finds its home at where the teaching—whoever it is and whatever they are doing—is done best.

But we have got to do all three of these things and more. But I cannot, in the timeframe that we are dealing with. This is where I unfortunately agree with my friend from California—I would love to fundamentally change the way in which we finance it, because it does not make sense. It is part of a historical anachronism that grew up, because this was a device that was there, and we hooked it on, and frankly there were political deals made between rural and urban sites. That is where disproportionate share came from, because you could pump money into the urban through dispropor-

tionate, and you got money different ways for rural. That is all the political history of where we are.

If we want to change it, we have to start with where we are. And so if we put a freeze on the total number of folks financed, if we limited the Medicare money to 3 years, and if we figured a way to allow you folk to make the decisions of how you operate within those two parameters, and we created a mechanism to allow money to go where you folks, in your training and teaching and educating capacity, decide best where it should be used—is that a big enough change to have an impact on the marketplace, on the profile of doctors and other health care professionals?

Dr. HEYSSEL. I think the 3-year limitation, if it were absolute, would have a real impact.

I also, I think, said that, you know, there are certain programs that really ought to go beyond 3 years; for instance, surgery, general surgery.

Chairman THOMAS. But can we not find a way to fund that outside of our payment, which then creates a real choice factor there that if folks want it, they are driven to do it.

Dr. HEYSSEL. Congressman Thomas or Chairman Thomas, let me give you a story; let me give you a story, though, which makes me hesitant about making these things change.

For 20 years at Johns Hopkins Hospital, the hospital, unlike most other places, did not fund fellowships leading to subspecialties in internal medicine, in any subspecialty in internal medicine and in some other areas.

And as you are probably aware, we have some of the largest training programs in these subspecialties in the country. And somehow or other, my colleagues on the faculty found ways to get money for that, generally from their own professional fees, I will say, more often than not.

To the extent that that is in jeopardy now, whether that would continue or not—but I am just saying that there are always other sources of funds for people to use, if they really are interested in a particular training program. And they are; that is their stock in trade and understandably.

Chairman THOMAS. No, I agree with you, because we have only complicated the problem because the traditional source of funds—largely from that excellent faculty, making money in the fees and the structure—is less and less available because of the patient profile in medicine.

Dr. HEYSSEL. Right.

Chairman THOMAS. The other concern I have is, you indicated a structure that grew up at Johns Hopkins which was not driven by government funding, but by a felt need.

Does it make sense to redirect where the money goes into the system? That is, do you really believe we can get a top-down reformation, or would it go faster and would it be better if we did a bottom-up; that is, we funded the folk who were looking for the training and the assistance?

And you mentioned, I think, Dr. Ludden, a voucher where folks would go where they believed they were being provided with the best education and training for their particular interest. And I

think today, clearly, it is a top-down structure. I think that has also driven specialties.

My former business was teaching in college, and I always loved to teach specific areas and narrow specialties. Graduate focus is a lot more fun than teaching GE courses. And I think most people get a satisfaction out of working in narrower structures. And they bring people on, and if there is no limit to that, you wind up having the structure itself specialized.

But if the students were looking with less of a reference to the marketplace than perhaps we would like—to the degree that the students are the ones who spend their dollars where they think it makes more sense, I think you get a "small d" democratic structure, but also one that is more market oriented.

What is your reaction to that?

Dr. LUDDEN. I react very positively to that general set of ideas. I think that anything that goes beyond your original statement, which was let you guys figure out what to do with it, which I think is something that has been tried and does not work and just in the ways that have been described here, that the kind of thing that you are suggesting—that is, to have the funding follow the resident—would be very positive and would allow us to be able to work on developing the kinds of innovative programs that are not just what primary care physician spots are open next year, but what kind are going to be open in 10 or 15 years.

Chairman THOMAS. And if you make it the 3-year provision, then it is in part up to those folks to figure out how, if they want to go beyond that, they have got to come up with funding to do that. But we know that we get them as far as we think it is essential that they need to go for society. And if they want to go for themselves, they go beyond that.

Dr. SHINE. My response to your first formulation—you asked the question—my answer would be yes. I think the things that you outlined would make a significant and profound difference.

Second, I do have some concerns about the mechanisms with regard to how you carry out the proposal you have just made in the sense that you have to hold the people who are in charge of the training or the education responsible for the outcomes of the education.

And the question again is: If the financing is separated, you have got to figure out how we connect these in terms of making sure that the overall educational venture is, in fact, a satisfactory one.

I would just point out to you that if you have some flexibility with regard to the rules about where people can train, a lot of the things that are happening in the market now and are happening with public policy will encourage, the "top-down" people to respond.

In New York City, for example, the cuts in Medicaid are clearly—they are inevitably going to move to much more Medicaid managed care. They are going to have to take care of those patients in a much better way outside of hospitals.

If there were flexibility in terms of the ways to pay for it and if those institutions in New York City had the opportunity, I would be very surprised if they were not prepared to enter into a very active program of residency education in Medicaid managed care in the city of New York.

What I am trying to say is, I think there is a potential synergism that is both top-down and bottom-up in terms of what is happening.

But incentives right now historically have not been there. If the incentives get changed, people behave differently, as you well know.

Chairman THOMAS. Well, I think one of the more positive statements that has been made is that I would love to have these structures that obviously have produced some of the finest doctors in the world to continue to work more intensively with nondoctor health professionals, nurses, and others, so that they are educated in the same general structure working with each other, so that when they move out into the health care world, there is not that historical hierarchical relationship, almost dictatorial, because that is not the case in the real world, and it would be very healthy, I think, to pick that up at an earlier period in their development.

OK. I appreciate very much your testimony. You folks are an enormous resource for us, given the time and the history that you have spent, but more importantly your online observations of the changes that have been made and your attempts to adjust in this real-world situation.

We will be back to you as we develop some of these themes in terms of trying to change the funding. It has to change. We want to understand the changes and deal with the unintended consequences as they come.

How far we can go is unknown now, but we have to move.

Thank you very much.

Our next panel—Ruth Hanft, Stuart Altman, and Michael Carter—thank you for being with us today. Any written statement that you have will be made a part of the record, without objection, and you may proceed as you see fit to inform and educate us in this area. And we will start with Dr. Hanft.

STATEMENT OF RUTH S. HANFT, PH.D., PROFESSOR, DEPARTMENT OF HEALTH SERVICES, MANAGEMENT AND POLICY, GEORGE WASHINGTON UNIVERSITY, WASHINGTON, D.C.

Ms. HANFT. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, I am pleased to be here this morning to talk primarily about the direct support of medical education through Medicare and other sources and also to raise the issue related to the difficulty in supporting primary care and ambulatory care education.

I am a professor at George Washington University. I would like to highlight key points that are in the more extensive testimony that I submitted for the record.

Currently the majority of direct support for GME in the United States comes from public and private third-party payers, the patient care revenues that flow primarily to the hospitals. These revenues support the salaries and fringe benefits of residents and interns. They support stipends or salaries to the teaching physician, the supervising physician, and they support the various ancillary services such as supplies, classrooms, et cetera.

Medicare makes a specific direct education payment to teaching hospitals based on the average per-resident cost at that specific

hospital in a base year inflated by the CPI, and there is a limit on the average payment after the fifth year of training. The formula also includes the ratio of Medicare patient days to total hospital patient days. And in 1994, it is estimated that Medicare paid $1.6 billion in direct costs to teaching hospitals.

This is not the only Federal source of support. Federal direct support also comes from the Veterans Administration and from the Department of Defense in their support of the residents and interns in the VA and the DOD facilities, and this is about 12 percent of the total residency support in the United States.

A number of States recognize direct medical education costs in their Medicaid payments and in their Medicaid reimbursement methodology. States also provide additional support through appropriations to their university hospitals and clinics, which is a declining source of support. Appropriations to county and municipal hospitals also provided support for residency programs. And finally, title VII of the Public Health Service Act provides about $60 million a year for special programs to support primary care education.

Private payers support graduate medical education as well. Although this support is not directly identified, it is incorporated into the cost or the charge base of the hospital. And as you have heard, as discounting continues, this source of support will end.

The major problem is that there is no basic source of support for education outside of the hospital, and as you heard from others this morning, this is where the education really needs to move to support managed competition and the managed care environment.

The Medicare program at the moment, except where the hospital will continue to pay the salary, does not provide support in HMOs, in public clinics, or in other ambulatory care settings that train residents and interns.

Thank you very much. I would be pleased to answer any questions that you might have.

[The prepared statement follows:]

TESTIMONY OF RUTH S. HANFT
GEORGE WASHINGTON UNIVERSITY

My name is Ruth Hanft. I am a Professor of Health Services, Management and Policy at the George Washington University.

Mr. Chairman, members of the Subcommittee. I appreciate the opportunity to discuss the direct support of graduate medical education and the issues related to the current methods of support.

The evaluation, structure and financing of graduate medical education is very complex, involving all allopathic medical and many osteopathic colleges, approximately 1200 teaching hospitals, over 90,000 interns and residents and numerous clinics, faculty, and preceptors. It is also a critical component of the provision of indigent care in the United States.

The major issues today include:

- The size and cost of the enterprise
- The appropriateness of the specialty distribution as between primary care and other specialties
- The mismatch between the structural changes in the health care delivery system, the structure and locus of current training programs, and their financing.

Structure of Graduate Medical Education

Medical education to the MD level is focused within and under the control of the medical school; graduate medical education, in contrast, tends to be hospital-based, with the direction of the program under a program director. The program director may or may not be the Chairman of a medical school department, a faculty member, the director of a hospital service or a designated attending physician at the hospital.

The accreditation bodies and processes are different for undergraduate medical and graduate medical education. Yet the education process should be a seamless continuum. Medical and graduate medical education are a cascade process for clinical education, involving teaching physicians, chief residents, senior residents, junior residents and interns, and 3rd and 4th year medical students. Frequently, particularly in academic health center hospitals, other health professions students participate. In each successive year, the medical student or resident assumes greater responsibility for patient care, moving from observer to participant to quasi-independent provider under greater or lesser supervision of a teaching physician. The degree of independence varies widely and is dependent on the capabilities of the student, the specialty, complexity of the case, philosophy of the program and the teaching physician and in some cases the payment status of the patient.

Residents not only provide patient care while learning but they also engage in research and teach more junior students. Teaching physicians simultaneously provide education and patient care.

There are more than 6000 residency programs approved in the United States, scattered over more than 1200 teaching hospitals, plus clinics. The majority of residency programs are hospital based and have been so historically.

Residency programs are reviewed and approved by residency review committees (RRCs) under the umbrella organization The Accreditation Council for Graduate Medical Education (ACGME), a private sector organization. There is no one organization that sets the total number of residency programs, residents, specialty distribution or sites of training. The RRC's do not directly establish overall residency numbers in the specific specialty but set qualitative standards such as volume of clinical cases, type of cases, etc.

The number of residency programs per hospital varies widely from one program to programs in every specialty and subspecialty. The degree of integration, with medical school faculty also varies widely from programs with no medical school affiliation, a declining number, to integrated medical school program that rotate

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among a number of hospitals. Most medical schools have multiple hospital affiliations including affiliations with Veterans Administration (VA) hospitals. Decisions on the mix and size of residency programs within a hospital are based on multiple factors:

The decision of the hospital to have graduate medical education; the desire of the chairman of the medical school department or division or the chief of service of the hospital to have or supervise a program; service needs of the hospital; clinical volume required for accreditation and faculty availability to supervise the program

While most graduate medical education takes place in teaching hospitals, there has been growing pressure to shift training to ambulatory care settings, and to provide education relevant to practice in a managed care environment. It has become increasingly difficult to provide appropriate graduate medical education exclusively in the inpatient setting, particularly the tertiary care setting, for the following reasons:

- The shift of locus of many diagnostic and treatment services to ambulatory care setting;
- Increasing severity of illness in the inpatient setting which narrows the scope of clinical experience
- shortened length of stay
- the rapid development of HNO's and other managed care arrangement.

However, the methods of financing graduate medical education have been a major barrier to the shift in the locus of education.

Sources of Financing Graduate Medical Education

History of Support

Until the end of World War II, the majority of physicians completed one year of internship and entered general practice. A number of factors changed the picture dramatically during the subsequent two decades. The advances in technology that spawned new knowledge and specialties; the demand for an increased number of medical schools and physicians which stimulated an increased need for graduate medical education, and the rapid growth of private health insurance that helped hospitals expand training programs.

The growth of private insurance and the passage of Medicare opened a stream of funds that could be used to support hospital-based graduate medical education. Hospitals incorporated these GME costs into their charge and cost structures. Medicare, at its inception, included these costs in its definition of reasonable costs. Two sources of funds helped to support GME; salary support for residents and supervisory physicians in hospitals and payments for patient care services to individuals newly covered by public or private insurance. These new sources of revenue enabled teaching hospitals to expand their residency programs to keep pace with expanding medical school enrollment, increase substantially the stipends paid to residents, and pay faculty for supervision of residents. In addition, these funds and physicians fees charged for services provided an additional steam of support for schools and faculty.

With the increased flow of third party payments in the 1970s, issues related to the effect of payment policies on geographic location and specialty decisions of new physicians began to arise, as well as issues of the equity of the financing as between sites of training and sources of payment. Specifically, reimbursement from third party payers has financed a greater proportion of the costs and charges for inpatient services than for outpatient services. Until recent changes in private health insurance policies designed to reduce costs, private hospital insurance rarely required cost sharing by the consumer. In contrast, reimbursement for outpatient services from third parties is usually structured to include deductibles (payment by the patient before the third party will pay) and coinsurance (a percentage of the bill paid for by the patient) and does not cover preventive services. It is therefore easier to support specialty training oriented toward inpatient care than primary care training oriented toward outpatient care.

Currently, graduate medical education is supported through several mechanisms with patient care support (mainly hospital support) dominating. The mechanisms are:

- Reimbursement from third parties for hospital care
- Fees paid to physicians for patient care services in inpatient and outpatient settings
- Special federal and state grants for primary care training
- State appropriations for university hospitals and city and county appropriations for public, general hospitals.
- Federal appropriations for Veterans Administration and Department of Defense hospitals
- Fellowship stipends from biomedical research sources, mainly federal.

Current Federal Support

Medicare Part A pays for graduate medical education through a complex methodology that recognizes direct costs and provide an indirect education adjustment. Reimbursement for both direct and indirect costs goes to the hospital.

Direct costs are calculated by multiplying the historic costs per resident in a base year (increased annually by a cost of living escalator) by the number of full time equivalent (FTE) residents. These costs are passed through as an addition to the DRG payment. There is a further limit on the payment of full costs. Full costs are paid for residents up to first certification in a specialty or five years, whichever is higher.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 (PL 99-272 Sec 9202) called for several modifications of what had been an open-ended direct cost pass-through for graduate medical education. These changes were basically designed to limit the growth in cost per resident and to place a disincentive on subspecialty training.

At first COBRA based the allowable cost per resident on the hospital-specific approved per resident amount for the cost reporting period beginning FY 1984. For subsequent periods, the per resident amounts were to be updated annually, based on changes in the Consumer Price Index. The per resident amount is multiplied by the weighted average number of FTE residents working in the hospital to obtain an aggregate approved amount. The law now allows the time residents spend on inpatient care activities outside of the hospital to be included "if the hospital incurs all or substantially all of the training costs in the outside setting." COBRA also applied two weighting factors - one related to length of training and the other to foreign medical graduate (FMG) status.

The factor relating to the length of training places a limit on the number of years a resident can be counted as an FTE. The limit is based on an initial residency period plus one year, not to exceed five years. The exception is participation up to two years additionally in certain geriatrics programs.

Medicare direct graduate medical education support was estimated at $1.6 billion in 1994. Graduate medical education costs are incorporated into the hospital charge base. The amount currently paid by third party payers is unknown.

The federal government, under Title VII of the Public Health Service Act, also provides direct grant support for residencies in general internal medicine, pediatrics and family medicine. While this support has been important in the establishment of family medicine residencies and ambulatory care training in primary care, the funding is relatively modest. Appropriations for primary care programs were $63 million in 1995.

The Veterans Administration provides salary support for residents and faculty in its own facilities. VA residencies account for 12 percent of all residencies. Military medical facilities also provide support for small number of residents.

State Support

The states have considerable discretion in setting hospital rates under Medicaid, including graduate medical education and teaching physician payments. Most states include the direct cost of graduate medical education but not the indirect education adjustment.

In addition to Medicaid payments, states provide support for undergraduate and graduate medical education through a number of different mechanisms. The majority (76) of allopathic medical schools are state schools.

States provide direct support of residencies through specific appropriations. The majority of this support is for family practice residencies.

States also provide operating subsidies to their university hospitals. Sometimes these subsidies are in the form of residents' salaries and fringes, sometimes they are subsidies for indigent care. Some states deficit finance or make up the balance between revenues and expenses.

Critics of current methods of graduate medical education financing have raised three issues:

1. The total number of residents being trained compared to the supply need and the number of US medical school graduates. There are approximately 17,000 graduates of US medical and osteopathic schools and 21,600 first year residents in allopathic programs, plus about 1000 osteopathic positions. The total number of residents in all years of residency has increased from 74,500 in 1985 to 96,500 in 1993. Over 20 percent of residents are not US graduates.

2. Most critics observe that there is an imbalance between the numbers being trained in primary care vs. other specialties. While the Medicare change to limit full support to five years was designed to reduce the incentive for specialty training, it has not yet worked.

3. Perhaps the most important criticism is the problem of supporting out of hospital training.

Primary Care Residencies and Ambulatory Care Training

A recent Institute of Medicine (IOM) study contained a number of commissioned papers on primary care residency and ambulatory care education financing. The following is quoted from the document:

"There are several generic problems in financing primary care residencies outside of the hospital setting. These problems may be of lesser magnitude in support of general surgery or other procedural specialties where patient charges tend to be substantially higher for services. The problems are summarized as follows:

- In the hospital setting, the resident and supervisory physician are paid salaries from hospital revenues with education costs separately recognized by Medicare and Medicaid and historically included in hospital charges. If a personal and identifiable service is provided by the teaching physician, a fee can be charged to the patient or insurer. Residents may not bill fees.

- In the outpatient setting not linked to a hospital (for Medicare) and for outpatient settings in terms of other insurers, the resident's salary and supervisory salary for the faculty must be generated from fees to the patient/third party or from grants from government and/or philanthropy. In the primary care specialties, the fee level, as noted extensively in the literature, are substantially lower than for procedure-oriented specialties. While there are two sources of patient car support for hospital-based or hospital outpatient linked training, there is only one in the nonhospital ambulatory care setting. Payments for physicians services as distinguished from payments for hospital services historically did not incorporate education costs since education was almost exclusively hospital-based in allopathic medicine.

Residents on Duty as of September 1 (Selected Years)

	All Residents		U.S. Medical School Graduates (USMG)		International Medical Graduates (IMG)		U.S. Medical School Graduates
	Total	First Year	Total	First Year	Total	First Year	
1993	96,469	21,616	73,763	15,836	22,706	5,780	15,554
1992	88,620	19,794	69,536	14,924	19,084	4,870	15,386
1991	85,516	19,497	68,499	14,805	17,017	4,692	15,481
1990	82,902	18,322	67,988	14,782	14,914	3,540	15,336
1985	74,514	19,168	62,479	16,495	12,035	2,673	16,319

> The development of faculty practice plans has been on a department/specialty basis similar to the organization of residencies, with the procedural specialties able to generate substantially higher revenues than primary care specialties because of the Medicare and private insurance charge structure. The revenues of these plans flow to the department with some small percentage flowing to the institution. Conceptually, all education, both undergraduate and graduate medical education should be an institutional responsibility. The organization of medical schools on a departmental basis and graduate medical education on a specialty/program basis, combined with the departmental flow of hospital and practice plan revenues leave the medical school institution with a paucity of flexible funds. Institutions that do not receive public appropriations, or where the appropriation is in the form of line items, unless the institutional percentage of practice plan revenue is substantial, have little ability to cross-subsidize. Where cross-subsidies are endemic among the missions of a medical school, they do not operate on an institution-wide basis in the medical schools for graduate medical programs. High earning departments and specialties retain the majority of their practice earnings for departmental and even division rather than institution-wide goals."

In summary, graduate medical education was hospital focused for many years. With the growth of technology and financing and the increase in the number of medical school graduates, graduate medical education expanded in numbers and specialties. Financing from Medicare and private insurance encouraged and sustained the expansion.

Medical and graduate medical education needs have now changed with the acceleration of the development of managed care and societal demands for primary care. This requires expansion of primary care training sites, particularly ambulatory care settings. There is a mismatch between educational needs to respond to managed care, the changing delivery system environment, and the method of financing graduate medical education.

Mr. JOHNSON [presiding]. Thank you, madam. We appreciate your testimony, and we will proceed with the other two gentlemen and then take questions for the panel.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Mr. ALTMAN. Mr. Johnson, thank you for allowing us again to come before this committee. As Chairman of the Prospective Payment Assessment Commission (ProPAC).

Mr. JOHNSON. It is always a pleasure to have you before us. Thank you.

Mr. ALTMAN. Thank you.

I want to switch the discussion, if you will, to where the dollars are. I realize and I do not want to diminish the importance of direct medical education and the discussion you had before about the training of physicians. But most of the money that flows from Medicare for graduate medical education flows in two other sources. One is what we call the indirect medical education adjustment, which is about $3.8 billion a year, and the second is the disproportionate share payments which come from Medicare, which amounts to another $3.4 billion.

You know, we have looked at this at ProPAC in all different ways. And what just astounded me—I was looking at the numbers this morning—a third of all of the money, of all of the Medicare money, that flows to the major teaching hospitals comes from these three sources: The indirect medical education, the direct medical education, and the disproportionate share payments. A third of all of their income comes from these three sources. So we are talking about substantial amounts of money.

As you have heard this morning, there is no question that the changing marketplace is putting our teaching hospitals at a big disadvantage, and we at ProPAC are very sympathetic to their problems. We do believe they should be protected.

But we are increasingly uncomfortable that Medicare now is being asked to disproportionately keep this important engine alive. And Medicare is under the gun. There is no question about it, that its rate of growth is higher than in the private sector, and there are all kinds of ways of looking for cuts.

And I support, and I know the Commission supports, moving away from using patient care dollars to support this public good, as Dr. Ludden said. So we have looked at what we would suggest you do.

And in the short run, we believe that it is appropriate to reduce the indirect medical education adjustment from about 7.7 percent of every 10 percent of the number of resident interns down to 6.7, which is a 1-percent reduction. That is $500 million, and then do that for 2 more years to bring the number down to where our estimates say it should be. So over a 3-year period, you would reduce the Medicare indirect payments by almost 40 percent.

We support, though, moving away from this patient care emphasis and developing some type of pool arrangement, whether it is through some State organization or community consortium that was in Senator Dole's and Senator Packwood's bill, some way of establishing a separate fund.

I want to make very clear, we do not support continuing that fund necessarily at the current levels. I think the discussion you had with the previous panel suggests that we may and probably do exceed the number of physicians we need; we surely exceed the number of specialists we need.

I personally might support a freeze. I think that is, in fact, generous. I think the number of residents could even come down.

I am rather surprised. If you look at the numbers, they have been going like this, and then last year they went like this. So I think if we went back even to 1992, we might be at a more stable base.

What is important is that we take a hard look at what is the appropriate role of government in funding this. Government does have a role, but it should not be—particularly the Medicare should not become the sole source of support. It needs to carry its share, but not be asked to carry it disproportionately. And we at ProPAC have tried to come up technically with a number that will allow you to make the appropriate adjustments.

Just one or two more numbers. By the way, in my testimony, I have given you a lot of information about the changes in the structure of the direct and indirect medical education, where the money goes.

It primarily goes to about 229, 230 of our major teaching hospitals. And these hospitals do disproportionately cover the number of uninsured in this country, and therefore they do need to be protected. But not all of them. Some of them actually are providing very little of such care.

So we would support again this phased reduction down to—from 7.7 down to about 4.7, which would save the country, or use it for other programs, about $1.5 billion.

Thank you very much.

[The prepared statement and attachments follow:]

TESTIMONY OF STUART H. ALTMAN, Ph.D., Chairman
PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission. I am pleased to be here today to discuss Medicare's payments to teaching hospitals. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

Hospitals with graduate medical education programs provide numerous valuable services, in addition to the routine patient care they furnish. They frequently treat the most complex cases and are the first to acquire and gain experience with new technologies and procedures. In addition, they provide much of the clinical training for the next generation of physicians. It is not surprising, therefore, that they have higher costs than non-teaching hospitals.

Over the years, the Medicare program has been an important source of revenue to help these hospitals finance the costs associated with their medical education mission. Many teaching hospitals also have been able to obtain higher patient care rates from private payers to help fund their educational activities. This extra revenue from private payers, however, is now at risk. Accelerating price competition is placing teaching hospitals at a disadvantage relative to other hospitals, since many private payers are not recognizing the added costs of maintaining graduate medical education programs.

In addition to the added pressure on teaching hospitals from the move to managed care in the private sector, Medicare's risk contracting program may also disadvantage these hospitals. Under current policies, Medicare's capitated payment amount, the AAPCC, includes average payments for medical education. The capitated payment, however, goes to the managed care organization, and there is no guarantee that they will use teaching hospitals or, if they do, that they will provide the extra payments to these hospitals. This does not mean, however, that managed care plans must contract with teaching hospitals or pay the rates that they did in the past. Managed care plans and teaching hospitals should negotiate their best deals. The challenge for the Medicare program is to find a mechanism to take advantage of the competition in the private sector, while appropriately recognizing the added value of teaching hospitals. We have suggested an approach that I will describe in a few moments.

The growth of managed care and increased competition in the private sector complicates the decisions you must make to constrain the rapid increase in spending for the Medicare program. The Commission believes that teaching hospitals furnish many valuable services to society and that Medicare should recognize the value of these services by providing some extra payments to these hospitals. Nevertheless, there are concerns about the limits to which the Medicare program should bear a disproportionate amount of the broader social responsibility for ensuring that the important contributions of teaching hospitals continue. This is not to say, however, that all the current teaching hospitals are needed or that there is not room for substantial improvements in the efficiency of these facilities or the number and mix of primary care and specialty physicians they produce. I believe, Mr. Chairman, that it is time to reexamine the role Medicare has played in financing graduate medical education and to consider alternative financing systems for the future.

I will begin this morning by briefly describing the important role teaching hospitals play in furnishing care to Medicare enrollees. I will then describe Medicare's medical education payment policies, focusing on the indirect medical education (IME) adjustment, and Medicare's contribution to the financial welfare of teaching hospitals. Finally, I will conclude by discussing some of the problems I see with Medicare's current policies and some alternatives you may wish to consider.

Payments to Teaching Hospitals

Teaching hospitals are an important source of care for Medicare enrollees. There are more than 1,000 teaching hospitals, about 20 percent of all acute care hospitals. These hospitals are responsible for over 40 percent of all PPS discharges and half of

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PPS payments. In 1994, teaching hospitals received $34 billion in PPS operating payments for the services furnished to Medicare enrollees (Chart 1). They also received payments for their capital costs, outpatient and other services they furnished, and direct medical education costs.

Of these hospitals, about 230 are classified as major teaching hospitals. Major teaching hospitals are defined as those with 25 or more interns and residents per 100 beds. Major teaching hospitals represent 4 percent of PPS hospitals, but were responsible for 10 percent of discharges and 17 percent of payments in 1994 (Chart 1).

The Medicare program provides two types of extra payments to hospitals with graduate medical education programs. First, teaching hospitals receive an adjustment to their PPS payments to reflect the added patient care costs associated with operating an intern and resident training program. This indirect medical education (IME) adjustment accounted for about 5.7 percent of total PPS operating payments in fiscal year 1994, or about $3.8 billion (Chart 2). As you can see in this chart, the amount of the IME adjustment steadily increased between 1989 and 1994.

Medicare also pays teaching hospitals an additional amount, separate from the PPS payments, for the direct costs of maintaining graduate medical education programs. These payments (referred to as DME or GME payments) cover resident salaries and benefits, the salaries of supervising physicians, office space, and other overhead. These payments totaled about $1.4 billion in 1994. In addition to the allowed salaries, physicians in teaching hospitals who directly supervise interns and residents can bill, under Part B of Medicare, for the services furnished by the residents that they are supervising.

In addition to these Medicare payments based on teaching status, many teaching hospitals also receive disproportionate share hospital (DSH) payments, related to the amount of care they furnish to poor patients (Chart 2). Teaching hospitals received about 67 percent of the $3.4 billion in DSH payments in 1994. The amount of DSH payments also has increased rapidly in recent years.

Indirect Medical Education Payments

Medicare's IME adjustment is a major source of revenue for teaching hospitals. More than 21 percent of Medicare's PPS payments to major teaching hospitals, and 6 percent to other teaching hospitals, comes from the IME adjustment. The amount of the payment depends on a hospital's teaching intensity, measured by the number of interns and residents per bed. Currently, per case payments increase about 7.7 percent for each 10 percent increase in teaching intensity. This increase in payments is substantially higher than the observed relationship between Medicare's operating costs per discharge and teaching intensity. The most recent ProPAC analysis indicates that, on average, a 10 percent increase in teaching intensity is associated with a 4.5 percent increase in Medicare operating costs per discharge. This difference between the observed cost relationship and the actual payments amounted to about $1.5 billion in additional payments to teaching hospitals in 1994.

For several years, the difference between the payment increase and the observed increase in costs has led the Commission to recommend a reduction in the amount of the IME adjustment. In ProPAC's *Report and Recommendation to the Congress, March 1, 1995*, the Commission recommends a reduction in the adjustment from 7.7 percent to 6.7 percent for each 10 percent rise in the number of interns and residents per bed. This is equivalent to a 13 percent reduction in the amount of the IME payments. If enacted, payments to teaching hospitals would decrease about $500 million. ProPAC believes that this should be the first phase of a three step process which will bring the teaching adjustment in line with the additional patient care costs teaching hospitals incur. We chose this phased reduction approach to allow teaching

hospitals time to make the necessary changes in the way they operate and to seek additional funding, if possible.

Graduate Medical Education Payments

Medicare also pays teaching hospitals a share of the direct costs of maintaining graduate medical education (GME or DME) programs. These payments totaled about $1.4 billion in 1994. Direct costs include resident's salaries and fringe benefits, salaries for supervising faculty, and institutional overhead that are not included in PPS.

GME payments are based on a hospital's per resident costs in a base year, updated to the current year. Hospital-specific per resident costs in 1990 ranged from less than $10,000 to more than $100,000 (Chart 3). Consequently, Medicare per resident payments also vary widely across teaching hospitals. Payments are somewhat higher if the resident is in an initial residency rather than in a second residency, or in a primary care rather than a specialty program.

One of the primary factors driving GME (and IME) spending growth is a continuing increase in the number of interns and residents (Chart 4). Virtually all of the growth in recent years is due to increases in the number of residents who graduated from foreign medical schools. There are large differences across states in the number and rate of growth of residents. This increase in the number of residents is especially troublesome in view of the growing concern that this country has an adequate supply of physicians, but too many specialists and too few primary care physicians.

Disproportionate Share Payments

There are now about 40 million people in this country without health insurance. Many of these individuals receive hospital care that is subsidized from other sources of revenue. The hospitals with the largest share of low income individuals qualify for Medicare and Medicaid DSH payments. In 1994, Medicare DSH payments totaled $5.1 billion, with about two thirds of these payments going to teaching hospitals. The federal share of Medicaid DSH payments was $10.7 billion and the combined federal and state share was $18.6 billion in 1994, although we don't have specific information on payments to teaching hospitals. In addition, the private sector has shared in subsidizing care to the uninsured through payments that are higher than costs. This subsidy from the private sector, however, may diminish as competition intensifies. Therefore, as Congress seeks additional ways to slow the growth in Medicare and Medicaid spending, it is important that reductions in DSH payments be carefully targeted so as not to further disadvantage hospitals that treat the largest number of uninsured patients.

The Financial Condition of Teaching Hospitals

The Medicare program has more than adequately compensated teaching hospitals for the costs of treating Medicare patients. Since the first year of PPS, teaching hospitals' PPS margins have exceeded those of other hospitals. Further, over the years the gap between the margins of teaching and non-teaching hospitals has widened (Chart 5). In 1993, major teaching hospitals had the highest PPS margins of any group of hospitals, 11.7 percent (Chart 6). In contrast, the PPS margin was 0.5 percent for other teaching hospitals, those with fewer than 25 interns and residents per 100 beds, and minus 4.0 percent for non-teaching hospitals.

Total hospital margins, which compare all hospital costs and revenues, show a very different pattern (Chart 7). Despite Medicare PPS payments that are almost 12 percent above costs, the total margin for major teaching hospitals in 1993 is only 2.7 percent, the lowest of any group of hospitals (Chart 8). The reasons for these lower total margins are difficult to disentangle. One definitely includes the large amount of uncompensated care many of these hospitals furnish. Others could include

inefficiencies in providing services and difficulties obtaining the revenue from private payers to support the extra costs of maintaining teaching programs. For smaller teaching hospitals the picture is different, with their total margins similar to non-teaching hospitals at 4.6 percent.

Although teaching hospital costs are higher than those of non-teaching hospitals, their costs per discharge have not increased faster than those of other hospitals over the past decade (Chart 9). As we have previously reported to you, the annual increase in hospital costs has slowed dramatically recently. Teaching hospitals have responded to the increasing cost pressures by slowing cost growth to the same extent as non-teaching hospitals.

It is important to point out, Mr. Chairman, that these aggregate PPS and total margins obscure significant variations among teaching hospitals. Even though the aggregate PPS margin was 11.7 percent in 1993, about 18 percent of major teaching hospitals had negative PPS margins (Chart 10). This figure, however, is much less than the 57 percent of non-teaching hospitals with negative PPS margins. Slightly less than 25 percent of both major teaching and non-teaching hospitals had negative total margins.

Next Steps

As I have described, in 1994 the Medicare program provided $5.2 billion in direct and indirect graduate medical education payments plus $2.3 billion in disproportionate share payments to teaching hospitals. These extra payments have helped many major teaching hospitals to avoid severe financial stress and to continue to provide access to care for Medicare enrollees, while maintaining their teaching mission. Accelerating price competition in the private sector is reducing the ability of teaching hospitals to obtain the higher patient care rates from other payers that traditionally have contributed to financing the costs of medical education. In addition, as Medicare's risk contracting program grows, teaching hospitals may not be benefitting as intended from the medical education payments included in the capitated payment.

The growth of managed care in the public and private sectors and the increased competition among insurers and providers will make your task of determining appropriate Medicare policies for teaching hospitals more difficult. While I believe that the reductions in the level of the IME adjustment that ProPAC has recommended are appropriate, it is likely that many of the institutions affected will have serious problems adjusting to them. But I have additional concerns that some policy makers are suggesting even larger reductions or reductions that take effect more quickly. The Commission believes such changes could have very serious consequences for this nation's teaching hospitals.

It appears to me that Medicare increasingly is carrying a disproportionate share of the financial responsibility for training tomorrow's physicians, nurses, and other health personnel. Some of these costs should be shared with private insurers or financed in a totally different manner.

The challenge, therefore, is to find a way for government and private payers to share the responsibility for supporting medical education. One approach that I believe has merit was outlined in Dole/Packwood and other proposed health care reform legislation last year. This approach would create consortia of hospitals, medical schools, and perhaps other community groups such as payers and purchasers involved in graduate medical education. The consortium would receive medical education payments from Medicare and from participating private insurers and distribute them as appropriate. It also may be desirable to include IME as well as GME payments to the consortia, plus the substantial Medicare Part B payments that teaching physicians receive for directly supervising intern and residents. The consortia could provide the incentives to train more primary care and less specialty physicians.

They could also ensure that training moved out of the hospital and into community sites when that was appropriate. Current Medicare policies, in contrast, provide financial incentives to train residents in hospitals, rather than in primary care settings, since the hospital may lose its IME and GME payments if the resident trains in another site.

This approach has another advantage as well. Since hospitals would receive additional payments from the consortia to cover teaching costs, they could negotiate payments with managed care plans for the costs of regular patient care on an equal footing with other hospitals. Such competition with other hospitals may also provide the stimulus for teaching hospitals to improve their efficiency. For this to work, of course, private payers would have to contribute to the funding for the consortia. Managed care plans, however, may find this an attractive way to market their services in a community, if it is known that they have developed relationships with teaching institutions. I believe that the Medicare program should develop a demonstration project to further test this idea.

A demonstration also could explore alternative ways to direct payments to teaching hospitals under Medicare's risk contracting program. As I discussed with you in my testimony last month, numerous improvements are necessary in the calculation of Medicare's capitated payment, the AAPCC, to enhance plan and enrollee participation and to achieve savings for the Medicare program. There also are a number of ways that payments to teaching hospitals could be improved in this program, and ProPAC would be pleased to work with you as you examine alternative approaches.

I would like to note, however, that providing a special pool to fund the costs of medical education should not absolve teaching hospitals of the responsibility to control their costs. As I described, since the beginning of PPS costs per case have grown at about the same rate in teaching and non-teaching hospitals. All hospitals, however, need to continue to improve their productivity and reduce their cost base, and Medicare's policies should continue to encourage this.

In conclusion, Mr. Chairman, teaching hospitals perform many important social functions in addition to routine patient care. In the past, the Medicare program explicitly and private insurers implicitly have subsidized these activities. As competition in the private sector increases, it is likely that the implicit subsidy will diminish. It is not appropriate for Medicare to cover an increasing portion of medical education costs. Nevertheless, you need to proceed cautiously to avoid sudden Medicare policy changes that could endanger the most important teaching hospitals.

For the long term, I believe that we must develop new policies to ensure that government programs and private insurers continue to share the burden of support for medical education, just as they have in the past. We would be pleased to continue to work with you and your staff as you seek better ways to pay for the services furnished by teaching hospitals.

This completes my formal testimony. I would be pleased to answer any questions you may have.

Chart 1: Distribution of PPS Hospitals, Discharges, and Payments by Hospital Group, FY 1994

Hospital Group	Number of Hospitals	Percent of Discharges	Percent of Payments	Payments in Billions		
				Total	IME	DSH
All Hospitals	5,261	100%	100%	$66.0	$3.8	$3.4
Rural	1,732	10	9	5.5	0.1	0.2
Urban	3,529	90	91	60.5	3.7	3.2
Large Urban	929	45	53	35.2	2.6	2.1
Other Urban	2,600	45	38	25.3	1.0	1.1
Rural Teaching	46	1	1	0.4	0.0	0.1
Rural Community	1,686	9	8	5.1	0.0	0.0
Other Urban	2,600	45	38	25.3	1.0	1.1
Major Teaching	329	18	21	13.9	2.4	1.1
Other Teaching	1,000	22	16	10.9	1.0	1.1
Non-teaching	3,932	60	54	36.1	0.3	1.1
Voluntary	3,000	64	60	39.9	3.0	2.2
Proprietary	1,000	12	11	7.1	0.1	0.3
Non-government	4,000	76	70	47.0	3.1	2.5
State government	1,261	24	30	19.0	0.7	0.9

SOURCE: ProPAC estimates based on ProPAC PPS payment model and fiscal year 1992 MedPAR file from data from the Health Care Financing Administration.

Chart 2. **Medicare Indirect Medical Education and Disproportionate Share Payments, Fiscal Years 1989-1994 (In Billions)**

Fiscal Year	IME Payments		DSH Payments	
	Amount in Billions	Percent of Total PPS Payments	Amount in Billions	Percent of Total PPS Payments
1989	$2.2	4.3%	$1.1	2.4%
1990	2.5	4.3	1.6	3.3
1991	2.9	4.5	2.2	4.1
1992	3.1	4.7	2.2	4.0
1993	3.7	5.6	2.7	4.1
1994	3.8	5.7	3.4	5.1

Note: IME = indirect medical education. DSH = disproportionate share.

SOURCE: Prospective Payment Assessment Commission. *Medicare and the American Health Care System: Report to the Congress*, June 1989, 1990, 1991, 1992, 1993, and 1994.

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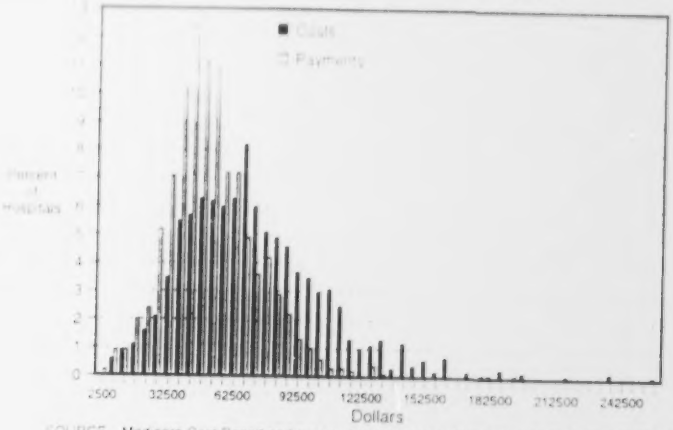
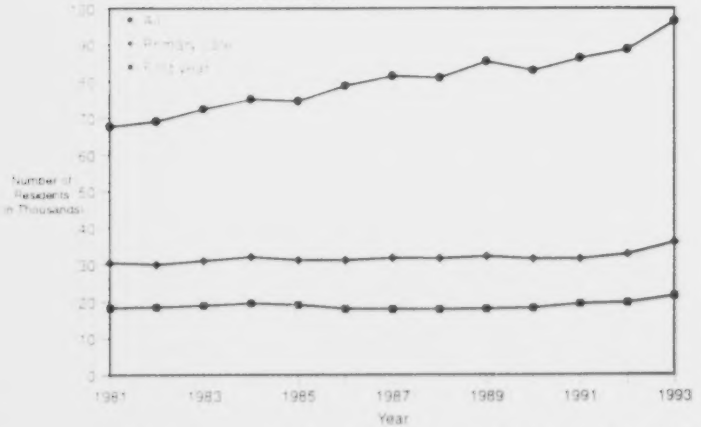
Chart 3. Per Resident Costs and Payments, 1990



SOURCE: Medicare Cost Report and per resident payment data supplied by the Health Care Financing Administration.

Chart 4. Number of Residents, by Type, 1981-1993
(In Thousands)



SOURCE: Selected medical education issues of the Journal of the American Medical Association

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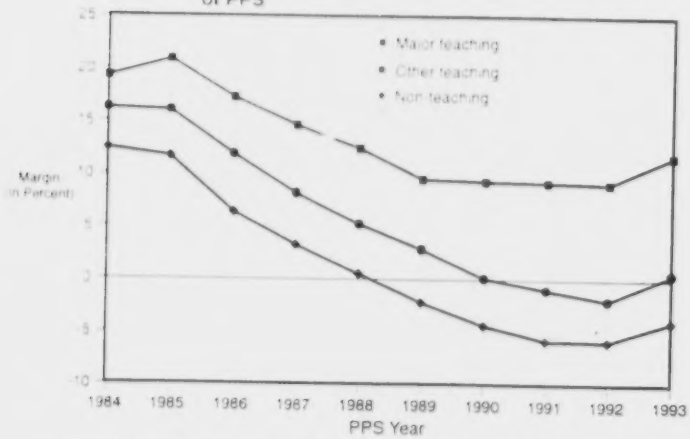
Chart 5. PPS Margins by Teaching Status, First Ten Years of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 6 PPS Margins, by Hospital Group, First Ten Years of PPS (In Percent)

Hospital group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10
All hospitals	4.5%	4.4%	3.7%	5.8%	4.7%	1.4%	-0.6%	0%	1.7%	3.3%
Urban	5.6	5.3	4.2	7.6	4.7	2.3	0.2	1.4	1.7	3.6
Rural	1.4	1.6	1.3	1.1	0.3	2.0	3.2	1.1	3.2	1.8
Large urban	6.1	6.1	4.2	7.6	4.3	1.7	2.3	0.5	-0.5	1.9
Other urban	5.2	4.5	4.3	7.8	5.2	2.3	1.0	2.7	3.4	1.5
Rural referral	2.4	1.8	2.5	6.1	4.8	1.5	-0.4	1.1	-0.2	0.2
Sole community	0.5	1.2	0.3	0.5	1.6	3.3	1.3	0.4	1.2	0.6
Other rural	1.4	1.7	1.4	2.3	2.8	3.9	5.3	1.5	5.8	4.0
Major teaching	4.8	2.8	1.2	4.6	2.4	2.5	3.3	3.2	2.1	11.7
Other teaching	5.2	5.2	4.6	8.1	5.2	2.5	2.1	1.3	2.3	0.5
Nonteaching	3.8	4.5	4.3	5.4	5.5	2.2	4.4	1.8	0.9	4.0
Voluntary	4.4	4.4	3.6	7.1	4.4	1.3	0.3	1.5	2.1	3.1
Proprietary	4.4	3.2	4.0	4.8	3.1	2.3	4.5	2.1	1.6	1.8
State government	4.5	4.4	3.2	4.3	4.7	1.4	3.2	1.6	1.4	3.0
Rural government	1.1	0.8	0.3	2.5	0.7	4.2	4.3	4.7	5.5	4.6

SOURCE: ProPAC analysis of Medicare and Health data from the Health Care Financing Administration.

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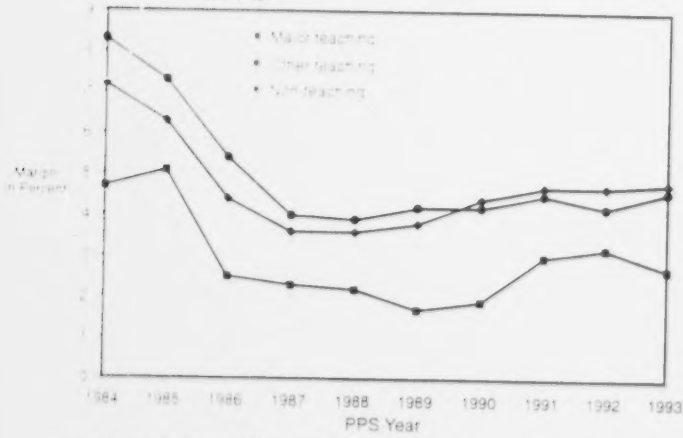
Chart 7 Total Margins by Teaching Status, First Ten Years of PPS



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

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Chart 4 Total Margins, by Hospital Group, First Ten Years of PPS (in Percent)

Hospital group	PPS 1	PPS 2	PPS 3	PPS 4	PPS 5	PPS 6	PPS 7	PPS 8	PPS 9	PPS 10
All hospitals	7.2%	5.4%	4.3%	3.4%	3.4%	3.5%	3.8%	4.3%	4.2%	4.3%
Urban	7.6	5.7	4.5	3.5	3.4	3.4	3.7	4.2	4.1	4.2
Rural	4.4	4.5	3.3	2.8	3.4	4.0	4.5	5.0	5.1	5.0
Large urban	7.5	5.4	4.0	3.0	2.7	2.6	2.7	3.3	3.4	3.5
Other urban	7.9	7.2	5.4	4.4	4.5	4.6	5.3	5.6	5.2	5.3
Rural referral	7.0	7.8	5.7	4.9	5.6	5.7	6.5	6.6	6.3	6.0
Rural community	4.7	3.6	2.1	2.3	2.1	3.1	3.9	4.6	5.0	5.3
Other rural	3.9	3.2	1.9	1.7	2.5	3.3	3.6	4.1	4.3	4.2
Major teaching	4.7	3.1	2.5	2.3	2.2	1.7	1.9	3.0	3.2	2.7
Other teaching	6.1	4.3	3.4	3.0	3.4	4.2	4.2	4.6	4.2	4.6
Non-teaching	7.7	6.3	4.4	3.5	3.5	3.8	4.4	4.7	4.7	4.8
Voluntary	7.4	5.6	4.1	3.5	3.6	3.6	3.9	4.2	3.9	4.1
Proprietary	9.4	7.6	5.2	4.7	3.9	3.9	3.9	5.3	5.7	6.4
State government	4.1	4.2	1.6	2.1	2.3	3.3	3.2	3.5	4.6	4.3
Rural government	4.1	3.8	2.1	1.9	2.3	2.8	3.5	4.3	5.2	4.4

SOURCE: ProPAC analysis of Medicare cost report data from the Health Care Financing Administration

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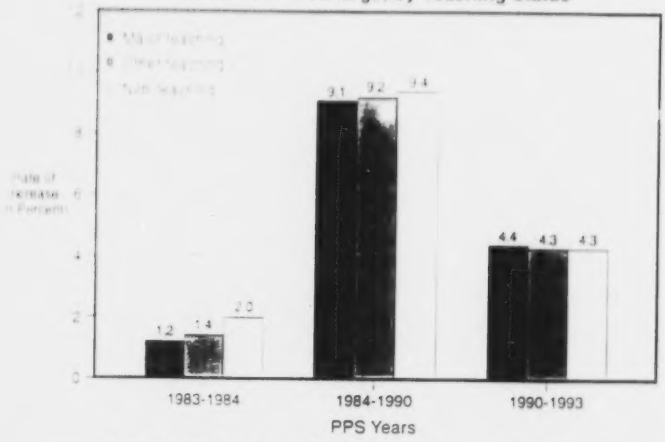
Chart 9. Annual Rate of Increase in Medicare Operating Costs Per Discharge, by Teaching Status



SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

Chart 10. PPS and Total Margins, by Hospital Group, Tenth Year of PPS (In Percent)

Hospital Group	PPS Margin	Percent w/ Negative Margin	Total Margin	Percent w/ Negative Margin
All hospitals	0.3%	54.1%	4.3%	23.8%
Urban	0.6	54.4	4.2	23.0
Rural	-1.8	53.8	5.0	24.7
Large urban	1.9	50.3	3.5	25.5
Other urban	0.5	59.3	5.3	20.1
Rural referral	2.4	39.5	6.1	8.7
Rural sole community	2.6	47.5	5.3	25.9
Other rural	-4.0	57.1	4.2	26.5
Major teaching	1.7	17.8	2.7	23.2
Other teaching	2.5	48.2	4.6	19.9
Non-teaching	-4.0	57.2	4.8	24.6
Voluntary	0.1	55.1	4.1	22.2
Proprietary	1.8	47.8	6.4	29.0
Urban government	3.0	52.2	4.3	20.9
Rural government	-4.8	55.5	4.4	27.5

SOURCE: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

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Mr. JOHNSON. Thank you, sir.
Dr. Carter.

STATEMENT OF MICHAEL A. CARTER, D.N.SC., R.N., DEAN, COLLEGE OF NURSING, UNIVERSITY OF TENNESSEE, MEMPHIS, TENN.

Mr. CARTER. Good morning, Mr. Chairman, and members of the committee. I am Michael Carter, and I am dean of the College of Nursing at the University of Tennessee at Memphis. I am also a family nurse practitioner.

The College of Nursing is a rather unusual entity in that it is an academic-based nursing program and does participate in graduate medical education because of a relationship with our University Hospital in Knoxville.

We prepare certified registered nurse anesthetists in this program, and GME does pay for a part of that. And we began this certified registered nurse anesthetist (CRNA) program in the thirties, making it one of our oldest programs.

I believe, however, that a number of changes are needed, for instance, if the legislative intent of this reimbursement is to be met in the future. As important as reimbursement is to us in the College of Nursing, I cannot tell you the amount of that reimbursement, and that is because the money goes directly to the hospital for a variety of cost-related issues and not to the College of Nursing for its budget. And yet I am responsible for paying for the cost of that program.

I understand that the original aim of Medicare reimbursement was to promote high-quality care for Medicare beneficiaries. In 1965, it was very appropriate that reimbursement be made to hospitals, since that was where the education took place and particularly that is where most nurses were trained.

But that is not the case today. Most nurses are not educated in hospital-based nursing programs, but are educated through universities and colleges and therefore do not qualify for GME.

For example, we have another problem in that our CRNA program in the past could perform all of its training in one hospital, but we cannot do that anymore, because that hospital does not offer all the services, and it is a major teaching hospital.

An example is that there are insufficient epidural anesthetics for women delivering babies for our students to be trained in that procedure, so they must come to Memphis for part of their training.

The situation is far more complicated in training nurse practitioners. We have offered a family nurse practitioner program at the master's level since 1973, meaning that we could not participate in GME for this program. We have graduated hundreds of these providers who are providing primary health care to thousands of persons in the lower Mississippi delta area of this country, one of the poorest regions in America.

None of the education of our nurse practitioner students takes place in a hospital—none of it. They are prepared in community-based clinics in inner-city Memphis and in rural Tennessee, Arkansas, and Mississippi. This also is where they practice when they are finished.

There is not any form of reimbursement available to cover the costs of educating nurse practitioners in these very rural clinics in which they are often one of two providers.

We must change the current system if we are to meet the original aim of Medicare reimbursement in preparing this work force.

To do this, I have two recommendations. First, I believe that we should stop the current payment for hospital-based nursing education programs, completely stop it. These programs prepare people at less than the college level and are not prepared to enter advanced practice. They must go on to college, obtain a baccalaureate degree, and then come into a master's program. The money needs to be redirected to meet the needs that we have, and this means paying for nurse practitioner, nurse midwife, and nurse anesthetist training programs.

The education of these students often does not take place in any hospital, and when it does, it takes place in multiple hospitals.

Second, I think that we need to pay the nursing education programs differently. Nursing education is organized quite differently from graduate medical education and does not tie itself to hospital-based educational programs. Our certification programs do not fit that as well.

This money could pay stipends for students, cover a part of the cost of the supervision of these students, and to pay for the costs of education borne by the primary care clinics.

I believe that if these two changes are made in the current GME reimbursement system that the Nation would be able to greatly expand the critically needed number of nurse practitioners, nurse midwives, and nurse anesthetists who, by the way, provide 85 percent of anesthetic services in rural communities, and that these individuals would expand their role in rural and other inner-city and underserved areas and would not add any new money to the system to do that. Rather we would make much better use of the current investment that Medicare makes in nursing education.

Thank you.

[The prepared statement follows:]

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Testimony of Michael A. Carter, D.N.Sc., R.N.
Dean, College of Nursing
University of Tennessee, Memphis

Good Morning. I am Michael Carter and I serve as the Dean of the University of Tennessee College of Nursing. The College in cooperation with our University Hospital in Knoxville, TN conduct a Master's degree program in nursing that prepares Certified Registered Nurse Anesthetists. We began this program in the early 1930's and today graduates of this program provide anesthesia to patients throughout the nation. We would very limited in our ability to operate this program without the money the hospital receives from the Medicare reimbursement. I believe, however, that a number of changes are needed if the legislative intent of this reimbursement are to be to be met today and in the future. As important as the reimbursement is to us, I can not tell you the amount of this reimbursement. This is because the money goes directly to the hospital and not to the budget of the educational program.

I understand that the original aim of Medicare reimbursement for a portion of the costs of nurse education was to promote high quality care for Medicare beneficiaries. In 1965 it was very appropriate that this reimbursement be made to hospitals for nursing education since that was where most of the education took place. Many changes have occurred since then. For example, in the area of preparing Certified Registered Nurse Anesthetists, all education could be done in one hospital in the past. Today, all hospitals do not provide all clinical services. Our University Hospital does not provide enough obstetrical services for our students to learn to competently administer epidural anesthetics. We must have the student leave Knoxville and spend at least one month of their training in Memphis.

The situation is far more complicated in the area of educating nurse practitioners. The College of Nursing has operated a Master's level Family Nurse Practitioner program since 1973. We have graduated hundreds of these providers and they today provide primary health care to thousands of citizens in the heart of the nation. None of the education of our nurse practitioner students takes place in the acute care hospital. They are prepared in community based clinics in inner city Memphis and in rural Tennessee, Arkansas, and Mississippi. When they graduate, this is were they practice. Medicare reimbursement for a portion of the costs of their education is not available to these clinics. These clinics care caring for mostly poor people. There is not any form of reimbursement to cover the costs of educating nurse practitioners in these clinics. We must change the current system of reimbursement if we are to meet the original aim of Medicare reimbursement.

I would strongly recommend the following:

1. Discontinue the current reimbursement for hospital based nursing educational programs. This money needs to be redirected to meet the emerging needs of Medicare beneficiaries. The need is the greatest for advanced practice nurses: nurse practitioner, nurse midwives, and nurse anesthetists - at the Master's or higher level. The education of these students does not take place in the hospital or in only one hospital.

2. Redirect the current reimbursement to the education of advanced practice nurses. The money needs to be made available to the nursing education program offering the program. This money would pay stipend support for full time students, cover a portion of the costs for clinical supervision of these students, and allow for some payment for the costs of education borne by the primary care clinics.

I believe that if these two changes are made in the current Medicare Graduate Medical Education reimbursement system that the nation would be able to greatly expand the critically needed number of nurse practitioners, nurse midwives, and nurse anesthetists particularly those in rural and other underserved areas without adding new money to the system. Rather, we would make a much better use of the current investment Medicare makes in nursing education.

Chairman THOMAS. Thank you, sir.

Dr. Altman, would you comment on the fact that he wants to take the dollars out of the hospitals?

I have been told that some the hospitals around the country, teaching hospitals, depend on this money, have come to depend on it—I do not know if that is right or wrong—and could absolutely fall flat, totally go out of business, if this funding mechanism were not kept in place. And I am not saying that it ought to be Medicare necessarily.

Maybe you can suggest some way that government can, you know, disengage itself, maybe redirect the dollars without it being Medicare dollars.

Mr. ALTMAN. Well, first, as I understand his testimony, he is focusing only on the amount of money that is being used for nursing.

Mr. JOHNSON. Nursing. I understand that, but I——

Mr. ALTMAN. And it is only what? I do not know—about $200 million. I mean, I do not want to sneeze at $200 million personally, but we are talking about a hospital industry that is consuming, what, upward of $100 billion.

I do not think, in and of itself, that is a lot of money. And I am not in a position to argue whether the hospitals should not play an appropriate role. My sense is that they do play an appropriate role in the training of some types of nurses. But I support his testimony that nursing, like other parts of medicine, is changing and shifting out of the hospital.

So I think it is deserving of a review. I am not so sure that the hospitals should not get a share of it, but whether they should get all of it or not, he may have a very good point.

Mr. JOHNSON. Thank you. I appreciate that.

Mr. Cardin, do you wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Dr. Altman, if I could get you to respond on one part of how the indirect medical costs are handled? As I understand it, Medicare figures in the IMC on a risk contract to a managed care program, even though the health care plan may very well not be using academic centers.

Can we make some adjustments in that philosophy—more quickly than perhaps some of the other issues—to try to make it sensitive to whether, in fact, the managed care programs, are using the academic centers?

Mr. ALTMAN. Well, there is no question that the AAPCC includes all of the payments that go in the Medicare program to the average patient in a fee-for-service environment. So it includes this indirect medical adjustment.

You could make that adjustment. My own personal view is that while you are taking this project on, that is such a small piece of the total, I personally would do it differently.

First of all, you have got to be fair to the system. To the extent that the indirect medical expense (IME) is being paid for—currently it is being paid for by lowering the payments to the other hospitals. The total is the same. The way the calculation is made is that when they calculated the amount of the IME, they took it out of the base, and therefore they lowered the average amount of the average payment to hospitals. So in a strictly technical sense,

a strictly technical sense, if you took the IME out, you should pay it back to the other hospitals.

Mr. CARDIN. I am not sure I follow you there. The cuts that you are suggesting on IME would not be redistributed to other hospitals. You are talking about absolute costs.

Mr. ALTMAN. Well, let me—we have recommended these cuts for a long time. This is about the fifth year we have recommended it. Up until this year, our recommendations had always been to put the money back where it came from, to put it back into the average hospital.

Mr. CARDIN. But not this year.

Mr. ALTMAN. This year we are cognizant of the special budgetary problems that the Congress and the people are facing. And for the first time, we said: If you are going to make a cut, this may be an area to cut out.

Mr. CARDIN. Well, then you still lose me on how it works on a risk contract.

Mr. ALTMAN. Well, no. I think there is a justification for taking the indirect out of the AAPCC. But I think the whole AAPCC structure needs to be readjusted.

Mr. CARDIN. One of the concerns I have about your suggested cuts, while they are logical in and of themselves, is that we don't have a logical system for reimbursing for graduate medical education.

Therefore if you take the type of cuts that you are referring to, whether it is fair or not fair, these facilities are dependent upon those funds. And if we just try to make a system that is not fair in the way it reimburses GME and cut the Medicare contributions without dealing with the overall problems, then we run the risk of really hurting some institutions that have a special role in our system that will not survive in the competitive environment.

Mr. ALTMAN. Well, I do not disagree with that. We have tried to find a number which we thought was appropriate and balanced. There is no magic number here. We think the payment is too high to those institutions.

And I want to make one point. There are big differences within teaching hospitals. There are some teaching hospitals that are making significant money on Medicare and are making significant money overall, and are treating almost zero, or very close to zero numbers of uncompensated care patients.

And then we have others that are running 20 to 30 percent where their bottom line is zero. I think we need a better targeting of that money.

Mr. CARDIN. Absolutely, we agree on that. The formula that we use, the built-in old distribution cost and everything else, does not make an awful lot of sense.

I guess my concern is, I am not so sure we should be tinkering with a system that does not work; we should be restructuring the system.

Mr. ALTMAN. Well, I would not disagree.

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. ALTMAN. Except I would disagree about changing the whole structure. The issue is, when you are dealing with the teaching ad-

justment, I just do not know exactly what to do, recognizing how high it is.

Mr. JOHNSON. Doctor, you did not really answer my question when I asked you if—and Mr. Cardin led into it—if these dollars are drastically reduced, are hospitals going to go out of business?

Mr. ALTMAN. Oh, now, if you get—I was just responding to——

Mr. JOHNSON. I know. The nurse part of it.

Mr. ALTMAN. Now when we talk about the big issue, I do get concerned. I mean, I am concerned about several of our major teaching hospitals. I am concerned about what Mr. Cardin said. If we sort of just reduce the amount of money at the same time that the managed care world and competition is squeezing down, I think we run the risk of some of these institutions falling into deep financial problems. I do.

Mr. JOHNSON. Well, I think there has to be some restructure, and I think you are hitting the nail on the head about where to get some of those reductions.

You also said the number of 229 major hospitals or 230. The panel before you corrected me when I used that number, which I got from you, and said 130 or so. Now——

Mr. ALTMAN. Well, it is the definition of "major." You know, there is major and there is major-major. You know, I mean—[Laughter.]

And then there is a major-major-major. You know, before you know it, there is only Johns Hopkins left. So what can I tell you? [Laughter.]

Mr. JOHNSON. Well, if we can keep that one, maybe we will be all right.

Thank you very much.

And Mr. Christensen, did you want to inquire?

Mr. CHRISTENSEN. Sure. I would like to get your opinions on what your vision of a graduate medical education should be. For example, what should the role of the hospitals in graduate medical education be in light of the current budget constraints that we are going to be facing in the next few months. What role should they play?

Ms. HANFT. Well, hospitals have to play a partial role. A physician and a nurse practitioner as well needs some hospital-based training.

The real problem is that the need is for training in HMOs, in managed care environments, and in clinics. And we have a mismatch of what are the educational needs versus the way the funds flow to support that.

Some hospital training is absolutely essential, and hospitals, particularly large teaching hospitals, also have numerous outpatient clinics as part of them, which are a major source of education for both nurse practitioners, residents, and physician's assistants. So you need some of both.

The problem is that the bulk of the funds flow to the hospital, and unless the hospital is willing to support the outpatient training in another locus by continuing the salary, Medicare does not pay for it. And that is the fundamental mismatch that we have in the financing.

Hospital training is essential, particularly for surgical specialties, for real differential diagnosis of complex cases. So you need both.

Mr. CHRISTENSEN. Dr. Carter.

Mr. CARTER. I agree with Dr. Hanft, that the necessity for hospitals is clearly there.

As an interesting point, the hospitals that participate in GME for nursing are not generally teaching hospitals. These are community hospitals. And the nursing program may be the only educational program that that hospital offers.

Those of us that are in systems such as mine at the University of Tennessee, where there is a single board that supervises the hospital and the nursing school, we are privileged to be able to do a small piece of that.

And therefore I think that we need to look very carefully at how that happens. But in the same way, the training cannot take place in one hospital, which has been unwilling to share the salary for that learner, that nurse anesthesia student, to be gone, so it is a difficult question to look at.

Our hospitals, for the most part, do not operate community-based systems, and in our State, where TennCare has become our new managed care arrangement for our former Medicaid, most of the individuals participating are not hospital affiliated.

Mr. CHRISTENSEN. Looking at the contributions that teaching hospitals make, which ones do you think are absolutely essential for us to preserve? Which ones do you think may be something that we could streamline?

Mr. ALTMAN. Well, that is a difficult—that really is a difficult question to answer.

Teaching hospitals play several very important roles. If you are in a big center such as Boston or New York or Houston where you have many, one or two less is not going to change the balance of that city or the health care.

But you could have what might be called even a semi-major teaching hospital in a middle-size Midwestern city, which is the critical deliverer of care in that area and is where most of the individuals are trained.

So I get uncomfortable about using any kind of formula to decide which one should go and which one should not.

In this case, I do believe to the extent that there is this market out there—it is not a market that I grew up learning about in economics, but it is a market of sorts, and therefore I think that may sort itself out, where the students want to go. If you reduce the number of students, you reduce the number of residencies, there will be a self-selection process taking place.

Plus I think some communities are going to hang on hard to what even might be viewed from sort of the elite as second-rate institutions. They may be very important for their communities, and their communities are going to support them.

So I really could not tell you which institutions should go.

Ms. HANFT. May I add one thing to that? If you look at family medicine residencies, they are basically not based in what we call the major 250 or 330 teaching hospitals. Most of those family medicine residencies come out of the community hospitals, and many of them are in smaller communities. That is one area where you cer-

tainly would not want to upend the current environment. Those residencies operate quite differently than the standard residencies in the large academic health centers.

Mr. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. HOUGHTON [presiding]. Thank you, Mr. Christensen.

Dr. Altman, gentlemen, it is nice to see you. Thank you very much.

I just have one specific question I was going to ask before I was crowned here to take the chair for the moment.

I am particularly interested in New York City, and as a matter of fact, I am surprised that when Mr. Christensen asked the question, you did not say immediately New York was the obvious place where the greatest hospitals should exist and be protected. [Laughter.]

It is not that I am parochial or anything like that.

But anyway, getting to the thrust of my question, health care in New York obviously is really dependent upon the Medicare GME payments, probably much more so than the average.

So, you know, people like myself—and I know Mr. Rangel and others—would worry about the impact of this whole reformation in freezing limits and limiting the number of residents, eliminating, foreign medical graduates, limiting payment for the first 3 years, cutting indirect adjustment—a big, big difference, because New York is different than Chicago, Boston, or Houston.

So I hate to see just a scythe go through the whole process and average it out where there is an undue concentration of teaching, research and residency which has to be protected.

Maybe all of you would like to make a comment on that.

Mr. ALTMAN. Well, I have looked quite extensively at the special interests of New York, and there is absolutely no question about it, that for many of these issues there is New York and the rest of the country. It is not even like: Well, there is New York and Chicago or New York and Boston. There is New York.

And it flows in several important dimensions. One is on the direct side. The amount of payments per resident is the highest in the country in New York. New York depends more heavily on the number of foreign-trained residents than any other part of the country. They receive a much larger proportionate share of the indirect teaching and the disproportionate share payments. There is absolutely no question that if you look at the numbers in New York, the impact of Medicare policy has a disproportionate impact on the current delivery system.

I will be glad to share those numbers with you. You probably know them. I am sure the medical——

Mr. HOUGHTON. No, I would like to see them.

Mr. ALTMAN. And how you deal with that is a complicated issue.

I am not a big believer in averaging. I do not think averaging makes sense in this area. I think we ought to decide from a policy point of view where you want the system to go. And, you know, in defense of New York and Boston and Philadelphia, the Nation looks to them to train physicians that go out all over the country.

So I would not average at all. That does not mean that those areas are not going to be affected if you cut back and probably will

be disproportionately affected. But if you average, it will be an absolute disaster for them.

Mr. HOUGHTON. Sure. Dr. Hanft, would you like to make a comment?

Ms. HANFT. Yes. I am quite familiar with New York, particularly the role both the New York Health and Hospitals Corp. plays in both care for the indigent and in their very large role in graduate medical education, institutions like Bellevue and Kings County Hospital.

I agree with Stuart that any of these changes will have a disproportionate effect on New York. But I would also raise the question with New York as to whether they need the number of specialty training programs they have in the city, whether there cannot be more of a collaborative effort across the number of medical schools to share some of those residencies, rather than each one having their own institutional spread of residencies through all the specialties.

So I think there is some effort that could be made by the educational institutions in New York to begin to soften the blow over time.

Mr. HOUGHTON. Well, in order to have that, if I could just interrupt for 1 minute—in order to have that effort made, there has got to be some sort of incentive.

Ms. HANFT. Yes.

Mr. HOUGHTON. So it is either an incentive internally or amongst the hospitals there or something which we do.

How would you suggest going about that?

Ms. HANFT. Well, as you will recall, some of the suggestions made earlier to change graduate medical education was the development of education consortia. And this is one area where New York might be a pioneer by getting the Cornells and the NYUs and the Mount Sinais and SUNY Downstate to really sit down and begin to decide what kind of work force does New York need, and how can they, as effective educational institutions, work together to begin to phase down areas where they may be producing too many specialists and to be able to establish the kind of training sites needed for managed care for the community health centers in New York and for the other service providers in the city and the State.

You could—Rochester has done a very effective job in outpatient training, for example, and in the training of family practitioners.

Mr. HOUGHTON. Yes. That would not have any impact on a disproportionate share of funding or something like that because of the unique nature of the city.

Well, look, the time has gone on, and I really appreciate this, and maybe we can get some other figures from Stuart on that.

Mr. ALTMAN. We will be glad to get them for you.

[The information requested was not received at the time of printing.]

Mr. HOUGHTON. That would be great. And I really appreciate your time.

Mr. ALTMAN. Thank you.

Mr. HOUGHTON. And we will have the next panel. Thank you so much.

Now I would assume that Messrs. Munson, Jacott, Schwartz, and Anderson will come to the table.

Thank you very much, gentlemen, for being with us. I am sorry I am the only one here. There will be others appearing in and out. You know, this is a rather peripatetic place.

But Mr. Munson is the executive director of the University of North Carolina Hospitals and speaking on behalf of the Association of American Medical Colleges.

Maybe you would begin.

STATEMENT OF ERIC B. MUNSON, EXECUTIVE DIRECTOR, UNIVERSITY OF NORTH CAROLINA HOSPITALS, APPEARING ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. MUNSON. Thank you, Mr. Chairman.

As you said, my name is Eric Munson. I am the chief executive officer of UNC Hospitals in Chapel Hill where I am trying to run a hospital that the basketball team can be proud of. [Laughter.]

I am also representing today the Association of Medical Colleges, and I appreciate the opportunity to testify on potential changes in the Medicare program and their effect on our Nation's important teaching hospitals.

Specifically I will comment on two Medicare payments to teaching hospitals, the indirect medical education and the direct graduate medical education payments.

Second, I want to call your attention to an issue of urgent and increasing concern to teaching hospitals, specifically the Medicare average adjusted per capita cost calculation.

Academic medicine and teaching hospitals are in a period of extraordinary and tumultuous change. My colleagues and I have enthusiastically engaged in this revolution in health care delivery. Further, we are part of a national movement to getting costs under control, improving the quality of care, and maintaining an ever-expanding access to care to all Americans.

My written statement includes just a few examples of the strategic initiatives some of us have undertaken to meet these national challenges.

The teaching hospitals are complex institutions. We have additional responsibilities in society that make it harder for us to compete in an environment where price is the only driving force. Teaching hospitals certainly provide patient care, but our care is frequently delivered to the most seriously ill, often using more sophisticated technology, and to the most disadvantaged persons in our society.

Everyone of us has an anecdotal experience of an immediate or extended family member who has benefited from having been referred to one of our country's many great academic medical centers. Your story may involve cancer or organ transplantation or hemophilia or cystic fibrosis or a complicated behavioral problem. We all have our stories, and we must remember these stories when we think about tinkering with the public program which has enabled most of these stories to have happy endings.

Teaching hospitals are also on the cutting edge of research and technology. We provide the environment for the conduct of clinical,

biomedical, and behavioral research and the introduction of new technologies.

To some degree, that is one of the historical purposes of the IME Medicare adjustment. At UNC hospitals, for example, we have a major lung transplantation program, and we may find the cure for cystic fibrosis one day soon.

Our research moves from the lab to the bedside and then into the community. I understand that today's conventional wisdom is that we are too expensive. We also know that in today's scientific age, we are priceless.

Teaching hospitals also serve as sites for the clinical education of all types of health care professionals, from physicians to nurses to allied health professionals. At UNC hospitals we have over 400 residents in 20 specialty and subspecialty training programs. We have 460 more students learning everything from physical therapy to cancer prevention to rehabilitation counseling.

We are working hard to increase the number of primary care physicians we train, and we have decreased the number of specialty positions we offer.

We learned just this week that 59 percent of the 170 UNC graduating medical students have selected residencies in primary care.

We continue to operate the country's finest demonstration of dispersed medical education through our Area Health Education Center. Through the area health education system program, students from all four North Carolina medical schools received training experiences all over the State.

Not only does this program foster exposure to primary care practice models in rural North Carolina, it also sustains the practicing professionals who serve as clinical role models in these remote settings.

All these additional responsibilities define today's teaching hospitals, but they also make our care expensive. Some policymakers and many payers expect teaching hospitals to be able to isolate the costs associated with their academic mission from the costs of providing care. We think that is pretty difficult.

Teaching hospitals finance these additional activities through a complex and delicate system of cross-subsidized revenues derived from patient care including payments from the Medicare program. In particular, teaching hospitals, including UNC hospitals in Chapel Hill, depend on DGME and IME payments.

In 1993, UNC hospitals received about $20 million for these two categories of payment, enabling us to fund, for example, an expanded breast cancer treatment program, losses in the Southeast United States' finest burn center, a new laboratory for gene therapy, a new training program in emergency medical services, construction of ambulatory primary care training sites for our primary care trainees, and placement of clinical work stations in the offices of rural primary care providers.

Increasing competition is making it more difficult to maintain our contract with society. In a marketplace where public and private insurers are not required to support their fair share of these responsibilities, the Medicare program's historical explicit payments to teaching hospitals take on crucial importance. Reduced

Medicare support will make it more difficult for teaching hospitals to sustain their role in society.

On this point, I find it paradoxical and even pathetic that the new crop of publicly held managed care companies are so eager to hire our product, specifically primary care doctors, but they have no interest in talking about the costs of production.

Medicare and Congress, on the other hand, have recognized from the beginning that in order to ensure quality care for the next and expanding generation of seniors, Medicare has a responsibility to help pay for the next generation of caregivers. Now, in my view, is no time to flinch on this contract.

I would like to now end my comments by turning to the Medicare AAPCC methodology, which Representative Stark alluded to earlier on and explain how that poses a threat to the future of teaching hospitals' ability to carry out their responsibilities.

In some areas of the country, as in California, Oregon, Minnesota, and Florida, this threat is real and immediate. In other areas such as mine where Medicare risk-based contracting is not as prevalent, the urgency of addressing this problem is only coming to the attention of teaching hospitals.

One thing is certain. As time passes and Medicare enrollment in risk-based programs grows, this problem will only increase in magnitude and become more difficult to solve. Failure to address the way in which DGME and IME payments and the disproportionate share payments are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals. Modifying this aspect of the calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table.

I urge you to address this issue in the context of the Medicare reform package currently being developed by the subcommittee. The AAMC staff would be happy to work with the committee to remedy this situation.

Before I close, I would like to make a personal biased observation. Our country's teaching hospitals—I have worked at three—are a national treasure. They are also fragile. In this era of competition, greed, and return to shareholders, I believe that those who champion education, research, and public service, the very domain of government, will be smiling when the last chapter is written.

Thank you.

[The prepared statement follows:]

TESTIMONY OF ERIC B. MUNSON
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Mr. Chairman and members of the subcommittee, I am Eric Munson, Executive Director of the University of North Carolina Hospitals in Chapel Hill. The Association of American Medical Colleges (AAMC) welcomes the opportunity to testify on the Medicare program's current law and policies relating to Part A payments for graduate medical education. The Association represents all of the nation's 126 accredited medical schools, approximately 300 major teaching hospitals that participate in the Medicare program, the faculty of these institutions through 92 constituent academic society members, and the more than 160,000 men and women in medical education as students and residents. In 1992, nonfederal members of the AAMC's Council of Teaching Hospitals (COTH) accounted for 6 percent of the nation's hospitals, but nearly 2 million, or almost 20 percent, of all Medicare discharges.

Teaching hospitals are among our nation's most complex enterprises. They are important components of the nation's health care system because they:

- provide all levels of patient care from primary to tertiary services often to the most disadvantaged members of our society;
- serve as primary sites for the clinical education of health professionals, including physicians, nurses and allied health professionals; and
- provide the environment for the conduct of clinical biomedical and behavioral research and the introduction of new technologies.

The health care delivery system is evolving as both public and private payers struggle to control health care expenditures, and academic medicine is responding positively to the changes in the environment. Teaching hospitals, faculty practice plans and medical schools have recognized the need for change within their own organizations and are actively engaged in helping to reformulate the health service delivery system, find ways to reduce the rate of increase in health care costs, improve accountability, and maintain or improve the quality of clinical service. Teaching hospitals are studying ways to deliver services more efficiently through partnerships with other health care organizations and are seeking new arrangements with payers of services. Medical schools, often in conjunction with teaching hospitals, are working aggressively to: increase the number of generalist physicians; identify new community-based sites for physician education; enhance the curriculum to reflect both new knowledge and new delivery paradigms; and assure the vitality of biomedical and behavioral research.

For example, at the University of North Carolina Hospitals, we are engaged in a number of strategic initiatives which seek to balance our traditional, statutory, public mission with the contemporary, market driven mandate to be an inexpensive provider of health care services. Some of our strategic initiatives include:

- expanding our network of primary care providers, through contracts and acquisition, for both service delivery needs and residency training sites;
- networking with other providers to cast a wider net for various managed care offerings;
- collaborating with our medical school faculty colleagues to "sell" our primary, secondary, tertiary and quaternary services to those purchasers of care with long term commitments to serve our market area; and
- marketing specific product lines such as lung transplantation to regional and national buyers as "Centers of Excellence."

With regard to graduate medical education, we are changing the blend of residency training positions available by increasing primary care opportunities and decreasing the number of specialty slots. We continue to operate the country's finest demonstration of dispersed medical education through our Area Health Education System (AHEC). The AHEC program provides all four of North Carolina's medical school students with training experiences throughout the state. Not only does this program foster exposure to primary care practice models in rural North Carolina, it sustains the practicing professionals who serve as the clinical role models in these remote health care settings.

While pursuing all of these strategic initiatives, we continue to service the people of North Carolina as the "court of last resort" - the place to which the sickest patients are sent - the place to which the poorest patients are sent - the place to where the cure for cystic fibrosis may be found - the place where teenage mothers go for education and health care. We know that today's conventional wisdom says we are too expensive, we know also that in today's scientific age, we are priceless.

In St. Louis, where the market is rapidly changing from one based on fee-for-service to managed care payment arrangements, St. Louis University Health Sciences Center is transforming itself into a more effective institution through structural change. The Health Sciences Center has consolidated the clinical practices of its faculty into a single unit to promote administrative efficiency and allow the faculty to develop and market product lines to health care purchasers. It is also consolidating the newly reorganized faculty practice group with the hospital into a single provider structure that aligns physician and hospital incentives and permits rapid and coherent responses to changes in the market. Soon, this new entity will merge with other health care providers in the community who have strong primary care bases and broader geographic coverage. This move will provide the Health Sciences Center with access to a sufficient base of covered lives, and to a network of providers who can provide ambulatory training opportunities for both medical students and residents.

In Kansas City, the University of Kansas Medical Center is concentrating not only on restoring health, but keeping people healthy through the formation of community focused networks. KU has joined with other health systems and two Blue Cross plans to form a corporation that operates a HMO in a two-state area and seeks to find innovative ways to benefit the communities it serves. KU Medical Center also has formed the Jayhawk Health Alliance with seven suburban and rural hospitals within 75 miles of the medical center.

These examples are typical of the actions that teaching hospitals and teaching physicians are taking around the nation to adapt to the new and rapidly changing marketplace. Academic medicine is prepared and willing to meet the delivery

system's new imperatives. But in a competitive environment based on price, teaching hospitals and medical schools face special challenges because these complex organizations have unique missions that, of necessity, add to their costs. The costs of these additional missions are borne in our current system by patient care revenues, including payments from the Medicare program, through a system of cross-subsidization. Patient service revenues have supported graduate medical education and other academic activities, and payments from paying patients have supported charity care patients.

The Prospective Payment Assessment Commission (ProPAC), in its March 1995 report to the Congress, notes that as the competition among health care delivery providers intensifies, the traditional patterns of subsidies across payers and providers will change (page 5). As the overall costs of medical care have risen sharply, private health care payers have adopted payment systems such as capitation, aggressive contracting and discounting that restrict their payments to cover only goods and services they believe are necessary and of identifiable, narrowly defined benefit to their enrollees. These types of payment arrangements increasingly do not recognize costs associated with the education and research missions of teaching hospitals.

In the newly price competitive environment, there is pressure on private payers to avoid paying higher patient care rates to fund the additional products of teaching hospitals that go beyond direct patient care. The AAMC believes that teaching hospitals, who are eager and willing to compete in the marketplace, will at some time in the short term future no longer be able to "make up the shortfall" to fund the costs associated with their academic missions through higher charges to patients. Revenue data from hospitals belonging to the AAMC's Council of Teaching Hospitals show that private and some public payers support about two-thirds to four-fifths of these additional costs primarily through increased charges for services. However, as ProPAC notes, "... increasing competition in the private sector is making it harder for teaching facilities to obtain the higher payment rates needed to cover the added costs of their graduate medical education programs" (page 7).

In the absence of a marketplace where all insurers or sponsors of patient care programs support their fair share of the academic mission of teaching hospitals and teaching physicians, the Medicare program's historical, explicit payments to teaching hospitals in support of their added responsibilities take on crucial importance. Even though Medicare payments support only a portion, between one-fifth and one-third of the costs associated with the academic mission, teaching hospitals rely heavily on the two Medicare payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) adjustment. Reduced Medicare support will make it more difficult for teaching hospitals to sustain their additional missions.

The AAMC believes that Congressional decisions on Medicare payment policy should be made in the context of their impact on the entire health care system. As ProPAC indicated in its March 1995 report:

> Medicare's payment policies must be considered in the context of changes occurring in the financing and delivery of health care. Among the most significant of these are the growth of capitated payment methods and managed care techniques in the private insurance market. ... Important factors contributing to these developments include constraints on payments from private payers and increased competition among providers and payers (page 3).

While the academic medical community understands the Federal government's need and commitment to reducing the budget deficit, and the growth in Medicare and Medicaid expenditures, teaching hospitals and teaching physicians would be particularly harmed by reduced Medicare support just when they are undergoing major change. I am pleased to appear before you today to comment on three issues relating to Medicare Part A payments of crucial importance to teaching hospitals:

- the role of Medicare payments for DGME costs in support of residency training;
- the importance of the Medicare IME adjustment to the financial viability of teaching hospitals; and
- the methodology for calculating the average adjusted per capita cost (AAPCC), the rate that the Medicare program pays to risk contractor HMOs.

Even under normal circumstances these three issues would be important, but they take on especially critical dimensions in the current environment. For example, while many proposals to change Medicare payments would affect both teaching and non-teaching hospitals, substantial reductions in IME and DGME payments would harm teaching hospitals disproportionately, seriously threatening their financial stability and affecting access to care and quality of care received by Medicare beneficiaries and other patients. Additionally, failure to address the way in which DGME and IME payments and the disproportionate share (DSH) payment are incorporated in the AAPCC calculation poses a threat to the financial status of teaching hospitals.

I urge the members of this subcommittee to consider carefully its Medicare payment policy recommendations. Teaching hospitals and teaching physicians play critical roles in our health care delivery system, and they could be damaged severely unless changes are crafted carefully and are based on an extensive understanding of the service, education and research missions of academic medicine.

Direct Graduate Medical Education Payments

Hospitals that train health professionals have multiple functions. In addition to providing medical care to individual patients, these hospitals provide the resources for the clinical education of physicians, nurses, and allied health professionals. To provide this formal, experientially-based clinical training, hospitals incur costs beyond those necessary for patient care. These added direct costs include: salaries and fringe benefits for trainees and the faculty who supervise them; the salaries and benefits of administrative and clerical staff in the graduate medical education office; and allocated institutional overhead costs, such as costs for electricity and maintenance.

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The Purpose and History of the Medicare Direct Graduate Medical Education Payment

When Congress established the Medicare program in 1965, it acknowledged that educational activities enhanced the quality of care in institutions and recognized the need to support residency training programs to help meet the public need for fully-trained health professionals. In drafting the initial Medicare legislation, Congress stated:

> Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program (House Report, Number 213, 89th Congress, 1st Sess. 32 (1965) and Senate Report, Number 404, Pt. 1, 89th Congress, 1st Sess. 36 (1965)).

Similarly, in the regulations governing the Medicare program, the Secretary of Health, Education and Welfare stated:

> It is recognized that the costs of such educational activities should be borne by the community. However, many communities have not assumed responsibility for financing these programs and it is necessary that support be provided by those purchasing health care. Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities (42 C.F.R. Section 413.85 [formerly Section 405.421(c)]).

Thus, since its inception the Medicare program has assumed some responsibility for graduate medical education costs, making separate payments to teaching hospitals for these costs. If there was ever an assumption that the "community" would take responsibility for its share of these costs, it certainly is not occurring in the current competitive environment.

Until the mid 1980s, Medicare paid for its share of DGME costs based on the hospital's historical and reasonable costs as determined by an audit. Reimbursement was open-ended in that a proportionate share of "reasonable and allowable" DGME costs incurred every year was "passed through" to the Medicare program. DGME payments were also open-ended in that there was no restriction on the number of years that Medicare reimbursement would pay for support a resident's training.

In April 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-72), which dramatically altered the DGME payment methodology. The legislation changed the DGME payment methodology from one based on annual historical DGME costs to a prospective per resident amount. The Medicare program now pays its proportionate share of a hospital-specific per resident amount based on audited costs from a base year and updated for inflation rather than on the basis of DGME costs actually incurred. Today, a hospital's DGME payment is calculated by multiplying the hospital's fixed amount per resident by the current number of residents and then multiplying that result by Medicare's share of inpatient days at the hospital. Other legislative and regulatory changes have been made since COBRA, but the basic methodology for calculating the DGME payment remains the same.

In addition to changing the payment methodology, COBRA placed limits on the number of resident trainee years for which full Medicare payment would apply. In a subsequent change, Congress chose to restrict full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years. The five-year count would be suspended, however, for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five-year level are reduced by 50 percent.

The change in DGME payment methodology required by COBRA, which the AAMC did not oppose, terminated the previous open-ended commitment to financing graduate medical education. Although COBRA limits DGME payments, it still acknowledges the historical scope of direct graduate medical education costs, including the salaries and fringe benefits of residents and supervising faculty physicians and institutional overhead costs.

Proposals to Change Medicare Payments for DGME Costs

Since the implementation of per resident payments in 1989, policy makers have proposed changes in the methodology to encourage residency training in generalist specialties and in non-hospital-based settings. The Association recognizes that the present system has not produced the number of generalist physicians that society may need in a reconfigured health care system. A 1992 Association policy statement calls for:

> an overall national goal that a majority of graduating medical students be committed to generalist careers (family medicine, general internal medicine and general pediatrics) and that appropriate efforts be made by all schools so that this goal can be reached within the shortest possible time.

The policy document's foundation rests on the implementation of voluntary, private sector initiatives. Among them is creating and maintaining incentive programs aimed at individual medical students, resident trainees, and practicing physicians as the best methods of inducing career choices in certain specialties. The Association's policy statement strongly endorses that private sector organizations and governmental bodies should join together in partnership to eliminate the many barriers that exist to meeting the need for generalist physicians.

With respect to the role of the Federal government, the AAMC policy statement recommends that the Medicare program and other third-party payers should adopt other reforms in physician payment designed to compensate generalist physicians more equitably by reducing the marked disparity in income expectations stemming from our current system of physician payment. A second recommendation is that payment methods for financing the direct costs of graduate medical education should not create nor perpetuate barriers to shifting the balance between generalist and non-generalist training.

Appropriate training experiences in ambulatory, community-based non-hospital settings are essential to produce competent physicians. As hospitals encourage shorter stays by more acutely ill patients, training in ambulatory and long-term care settings is needed to supplement the educational experience provided in hospitals to assure that residents receive comprehensive clinical training.

The nation's medical schools have implemented programs to increase the awareness and attractiveness of generalist medicine. New clerkships emphasize more experience in ambulatory settings. Courses with a primary care focus have been added during the pre-clinical years, and new curriculum strategies, such as primary care tracks and competency based curricula, are being developed and implemented. Role modeling and mentoring opportunities are being provided through classes, formal mentoring programs, or the assignment of advisors and the development of primary care interest groups. Schools have convened primary care task forces, appointed new Associate Deans for Primary Care, and developed new departments of family medicine and divisions of general internal medicine and general pediatrics.

The AAMC is pleased to report that medical schools' efforts, in combination with market forces, have been rewarded as medical students' interest in generalist practice continues to increase. Although data on medical students' career choice from as recently as the graduating class of 1989 show a declining selection of the generalist specialties, more recent data signal that medical school graduates continue to notice the changes in the health care environment. In 1994, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased again. Of graduating medical students, 22.8 percent indicated an intent to choose a generalist career in 1994 compared to 14.6 percent in 1992 and 19.3 percent in 1993. In addition, results from the National Residency Matching Program (NRMP), released on March 15, 1995, showed that medical students "matched" into family medicine residency programs at the highest rate in the NRMP's 43-year history. Over 2,000 graduating seniors from U.S. medical schools, or 15.4 percent of those seeking first-year residency positions, matched into a family medicine residency. This compares to 14.0 percent of all U.S. seniors in 1994.

Personal incentives such as loan forgiveness, tax benefits, and other inducements, such as narrowing the income gap between generalist and non-generalist physicians, are more likely to result in greater numbers of U.S. medical school graduates entering the generalist disciplines. If monetary incentives are to be provided, they should be aimed at individuals, not hospitals and their sponsored residency programs. There are also a variety of federally sponsored student loan repayment programs that could be bolstered.

Our present system for graduate medical education has much to commend it. The AAMC appreciates the need to study different payment policy options. However, it is important to note that many options are interrelated in sometimes unexpected ways that, if adopted, could result in unintended consequences, such as the need for a regulatory mechanism. The need for re-examination notwithstanding, Congress should carefully consider changes in Medicare payment policy that would reduce the program's current level of support for DGME, and yet fail to encourage the attainment of desirable public policy goals, such as an increase in the number of generalist physicians. This is particularly true in light of diminishing support from other payers and the present unlikelihood of establishing an all-payer fund for graduate medical education.

In addition to proposals to shift the balance of generalist and nongeneralist physicians, policy makers also have expressed interest in limiting the variation in hospital specific per resident amounts. Many of these proposals are intended to limit the growth in Medicare expenditures. Among the more frequently mentioned proposals which seem to have captured the attention of some policy makers are:

- encouraging the development of non-hospital-based ambulatory training sites by allowing entities other than hospitals to receive Medicare DGME payments and changing payment rules for the IME adjustment;
- weighting payments by specialty to encourage training in the generalist specialties;
- constructing a national average per resident payment methodology that would reduce the variation in hospital specific per resident payments; and
- limiting payments based on certain types or a defined number of residents.

Each of these proposals and their potential impact on graduate medical education is discussed below.

Encouraging the development of non-hospital-based ambulatory training sites. Increasingly, care that was delivered in a hospital inpatient setting is now being provided in clinics, ambulatory surgery centers, community health centers, and other alternate sites. As health maintenance organizations and other forms of managed care delivery systems command a larger share of the health care delivery market, medical educators have recognized that if physicians are to practice appropriately in these settings, it is important for them to be trained in similar settings.

Changes are needed to ensure that training sites chosen by residency program directors are selected because they offer appropriate educational experiences, not because they are more easily funded. Some changes in Medicare DGME funding should be considered to encourage residency training in non-hospital, ambulatory sites. The law regarding Medicare DGME payments is very explicit in stating that DGME payments may be made only to hospitals. On the other hand, the law and implementing regulations allow hospitals to receive DGME payments for the training of residents in non-hospital, ambulatory settings (subject to certain requirements). Although an ambulatory site may not at present receive a Medicare payment directly for any DGME costs it might incur, nothing in the law prevents it from negotiating for a payment from a hospital for the residents that the non-hospital site accepts.

The AAMC believes that the funding for graduate medical education should support residents and programs in the ambulatory and inpatient training sites that are most appropriate for the educational needs of the residents. The Association believes that Medicare DGME payments should be made to the entity that incurs the cost. Recipients of

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payments could be teaching hospitals, medical schools, multi-specialty group practices or other organizations that incur training costs. The AAMC strongly encourages the formation of formal associations, or graduate medical education consortia, to assure the continuity and coordination of medical education and to serve potentially as the fiscal intermediary in distributing payments across various training sites. However, the AAMC does not support payments being awarded directly to training programs, since ultimately the organization of which the program is a part must determine the institutional commitment to graduate medical education.

The AAMC urges Congress to consider modifying the statutory requirement that only hospitals may receive Medicare DGME payments and to permit other entities to receive the payment if they incur the cost of training. A payment methodology would have to be developed based on the costs of training at those sites. To explore the issues inherent in such a change, the AAMC would support an effort to design a research and demonstration project to encourage the development of new integrated training sites and/or GME consortia. Under the project, the Administration could experiment and monitor the impact of allowing non-hospital sites to receive DGME payments if they run the training programs and incur the costs.

However, shifting residency training to non-hospital sites may negatively impact the level of a hospital's IME payment. Many policy makers believe that the IME adjustment in the Medicare inpatient PPS serves as a disincentive to conducting graduate medical education in non-hospital, ambulatory sites. They argue that the current rules governing the count of a hospital's trainees for IME payment purposes provide an incentive to keep residents in certain areas of the hospital. Hospitals are allowed to count only residents in the PPS-related units of the hospital, or its outpatient department. If a teaching hospital sends a resident for a training experience rotation to a nursing home or a clinic in a rural area, for example, the hospital may not count the time that the resident spends in these settings for IME payment purposes.

The AAMC encourages the elimination of barriers to graduate medical training in non-hospital, ambulatory settings and/or inner city and rural sites while maintaining the current institutional PPS payment structure. The Medicare IME adjustment, which compensates teaching hospitals for their higher operating costs due to severity of illness, the provision of a broader scope and greater intensity of services, and the presence of physicians-in-training is inpatient-based. To address this apparent barrier to development of non-hospital, ambulatory training Congress could, for example, allow hospitals to count hospital "sponsored" residents in non-hospital settings for IME payment purposes. To maintain the budget neutrality of such a change in the counting rules, Congress could require a freeze on the number of inpatient residents that the hospital could count for IME payment purposes, setting a limit on the aggregate payment. The AAMC would be pleased to work with the committee staff to develop this proposal further and to formulate other budget-neutral policy options.

Weighting Payments by Specialty. For several years, some policy makers have proposed changes in Medicare payments for DGME costs that are intended to provide incentives to encourage the training of generalist physicians and to eliminate the variation in hospital-specific per resident amounts. Additionally, these proposals would reduce the Medicare program's role in GME funding.

For example, Medicare DGME payments could be based on a per resident amount that would then be weighted based on the specialty area that a resident is pursuing. Thus, the Medicare program would make a higher payment for a resident in a generalist specialty than for a non-generalist resident. Such a proposal, if adopted, would replace the current hospital-specific Medicare payment methodology with a system based on fewer multiple rates. Thus, a hospital's total direct GME payment would be based not on its costs, but on the specialty mix of its trainees. Some policy analysts believe that these type of proposals would not only eliminate the variation in direct GME payments, but also would offer incentives to produce more generalist physicians. The proposal would attempt to accomplish this policy goal by paying relatively favorable amounts for generalist residencies, and substantially less favorable payment amounts for all other residencies.

The Association opposes proposals that are intended to stimulate the production of generalist physicians by weighting DGME payments by specialty. Although the AAMC strongly supports more individuals entering generalist practice, the Association does not believe that this proposal would achieve its intended objective of encouraging the training of more generalist physicians. Proposals to weight Medicare DGME payments by specialty would have a negative effect on most hospitals' DGME payments, depending on the hospital's specialty mix of resident trainees.

Additionally, data on career choices of medical school graduates indicate that medical students' selection of residency training programs is affected not by Medicare payments to hospitals, but by market conditions and personal suitability to a particular specialty. At present, there are more generalist training positions offered to medical school graduates than there are interested students to fill them. The task at hand is not to increase the number of generalist training positions, but to increase the attractiveness of the training positions already available.

In its March 1993 report to the Congress, the Physician Payment Review Commission (PPRC) concluded that weighting DGME payments to hospitals is undesirable. The commission indicated that there was already a sufficient number of existing generalist training slots, and weighting would have little influence on hospital management's and residency program directors' decision making.

Changes in physician manpower supply, pressure from both federal and private payers to constrain the growth in health care expenditures, and changes in medical care delivery have produced significant tensions for residency and fellowship training programs. At the same time, the Association recognizes the frustration of government policy makers in assuring the public has access to an appropriate specialty mix of physicians. The AAMC supports strategies to develop additional generalist physician manpower, but proposals to weight Medicare DGME payments based on specialty, if enacted, would only contribute to the instability of GME funding. Strong residency programs require continuity of effort and stable

support. If future generations of Americans are to have appropriate access to well-trained physicians, we must maintain and strengthen our medical education system, including its residency training component.

Constructing a National Average Payment Amount for DGME Costs. Last year, during the debate over comprehensive health care reform, some policy makers recommended the development of a national average per resident payment methodology with payment adjustments for regional differences in wages and/or wage-related costs. In some instances, the proposals excluded certain types of costs, such as direct overhead costs or allocated institutional overhead costs. These changes were suggested in the context of a package of proposals for graduate medical education reform, including an all-payer funding mechanism that was to be separate from payments for patient care services.

The AAMC supports the continuation of the current Medicare per resident payment method based on hospital specific costs. The AAMC believes that a national average payment method would fail to recognize structural factors that legitimately affect a hospital's per resident costs. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty supervisory costs, being borne variably by the medical school or teaching hospital. The diversity of support for the costs of faculty is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Wide variation in per resident amounts exists among hospitals in the availability and amount of support from non-hospital sources, including faculty practice earnings and state or local government appropriations. While some proposals would adjust the Medicare national average per resident payment for differences in wages and other wage-related costs, these other structural factors would not be reflected in the national average payment methodology, creating inappropriate winners and losers.

Last year, at its January 20, 1994 meeting, ProPAC discussed recommendations on graduate medical education financing for its March 1994 report. Commissioners reviewed a staff analysis of graduate medical education costs and payments and noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned those who prefer moving to a national average payment methodology for residency costs without incorporating a number of adjustments in the payment system. Pointing to the commission's eleven-year experience with the prospective payment system, the first attempt by the federal government to standardize payments based on national averages, Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's preliminary analysis of graduate medical education costs found significant relationships between per resident costs and hospital size, its share of full time equivalent residents in the outpatient setting, its share of costs related to faculty physicians' salaries, geographic region, location in a metropolitan statistical area, and area wages.

The AAMC also supports the current methodology because it recognizes all types of costs, including salaries and fringe benefits of the faculty who supervise the residents, direct overhead costs, such as malpractice costs, and the salaries and benefits of administrative and clerical support staff in the graduate medical education office, and allocated institutional overhead costs, such as costs for maintenance and utilities. The AAMC opposes proposals to exclude certain types of DGME costs, such as faculty supervision costs or overhead costs, from the calculation of the Medicare per resident amount. The AAMC believes the level of payment should recognize all types of costs, including direct overhead costs such as malpractice costs, and clerical support. The current method recognizes the diversity in how graduate medical education is organized and financed. Further, ample faculty supervision is necessary to maintain appropriately residents' development in an environment of rapidly changing patterns of practice. Graduate medical education in all specialties is based on the premise that residents learn best by participating, under supervision, in the day-to-day care of patients. Supervising physicians must judge the clinical capabilities of residents, provide residents with the opportunities to exercise progressively greater independence, and ensure that the care of patients is not compromised. This supervising responsibility requires substantial time and commitment, and must be compensated.

The AAMC believes that, within these policy parameters, consideration should be given to changes that would ensure equitable, economically justified payments among training sites. The AAMC intends to pursue the development of alternative payment proposals that would recognize the significant diversity across institutions that participate in graduate medical education. For example, one suggested alternative has been to develop a methodology that pays hospital specific costs within a payment corridor, such as within two standard deviations of the average per resident amount. The AAMC would be pleased to share our payment policy proposals with subcommittee members and staff, and with the administration, as the policy options are refined.

Limiting Payments Based on Certain Types or a Defined Number of Residents. Education in the practice of medicine includes both undergraduate medical education in a medical school and graduate medical education in a teaching hospital or other clinical site. Because medicine involves a number of different specialties, each specialty area has developed its own residency training period. The AAMC believes that the variable length of training for each specialty area is appropriate and in the national interest, but recognizes that Medicare payment policies must be balanced. Some policy makers have proposed imposing additional limits on the length of time for which the Medicare program should provide its support.

Currently, the Medicare program limits the number of years for which it will provide full support. Congress has restricted full support to the direct costs of those residents within the minimum number of years of formal training necessary to satisfy the educational requirements for initial board certification, up to a maximum of five years.

As noted earlier, the limit is waived for a period of up to two years for training in a geriatric residency or fellowship program. Payment for residents beyond either the period for initial board certification or the five year level are reduced by 50 percent.

The AAMC believes that any further limitation on Medicare support for graduate medical education should not be arbitrary or inconsistent with adequate minimal residency training. For example, some have suggested that the Medicare program should pay only through the period required for initial board certification in a specialty or pay only for a three-year period, regardless of the specialty. Because the initial skills and techniques needed by different specialties require different lengths of training, the AAMC believes that support through initial board eligibility is an essential minimum training period that every patient service payer should help finance.

In its March 2,1985 report, PPRC also rejected as unwise the options of paying only for primary care positions or only for the first three years of training. (page 69). While the commission was aware of the need to increase the proportion of generalist physicians, it concluded that the nation would continue to require well-trained physicians in all specialties and that such a policy would not be "sufficiently flexible" if changes in the health needs of the population called for physicians in specialties that required more than three years of training.

It should be noted that paying only through the period prior to initial board eligibility, or paying for three years regardless of specialty, would result in a potential interaction with other areas of Medicare payment policy, notably in the Part B component. If Medicare Part A payments were limited to the initial board eligibility required to become a competent practitioner, advanced residents could be thought of as physicians in the early years of practice whose services could be supported from the physician component of Medicare. Consequently, if residents beyond initial board eligibility or beyond three years could not be counted for Part A hospital payments, then individuals in residency years which would not be included in a hospital's payments should or could be allowed to bill under Part B for services rendered.

As long ago as 1976, the Institute of Medicine (IOM), in a study on Medicare and Medicaid reimbursement policies, recommended a similar payment method, called the "unified method of payment," for certain institutions. Under this method, licensed physicians both teaching physicians and house officers would be allowed to bill fees for services rendered. The IOM report also maintained that whether the teaching physician or the house officer delivered the service should not affect the level of payment for the service provided. Residents who had not completed the first year of post-MD/DO training (or the second year based on state licensure requirements) would be paid on a Part A basis as the hospital. Such proposals raise questions about the role of faculty supervision in graduate medical education. If policy makers consider imposing further restrictions on payments beyond the current five year or initial board eligibility period, then the potential impact on total Medicare payments, including Part B payments, also should be understood.

Another proposal made by some policy makers is to limit Medicare DGME payments only to graduates of U.S. medical and osteopathic schools. They point to a growing consensus that U.S. medical and osteopathic schools are training an adequate number of physicians for our nation and that an excessive number of foreign-trained physicians are entering residency programs in the U.S. where they are supported by patient service revenues, including Medicare payments.

It should be understood that for some hospitals, where residents provide a large proportion of patient services, the immediate elimination of Medicare support for international medical graduates (IMGs) would cause substantial access and service problems for Medicare enrollees. One of the issues that policy makers would need to address in enacting such a change would be the implementation of a process and a time table so that patient access to services would not be reduced precipitously. Additionally, a gradual transition period with adequate, permanent replacement funding would be needed to enable hospitals and their medical staff to modify programs, personnel, and services while maintaining access to patient care.

A third proposal advanced by some policy makers would limit Medicare DGME payments to a defined number of residents. One option could be to limit payment to the current number of residents in the training system. More aggressive options might be to place an aggregate limit on the total number of positions, for example the number of U.S. graduates plus some additional percentage. Policy makers should understand that this latter proposal requires the establishment of regulatory mechanisms to allocate the funding among training institutions.

Graduate medical education rests upon a relatively fragile interweaving of multiple institutional capabilities, individual goals, foregone compensation and personal initiative. It is a system that could be easily damaged unless any changes to it are carefully crafted and are based on an extensive understanding of both the nature of the teaching hospitals in which it is embedded and the nature of graduate medical education itself.

Indirect Medical Education (IME) Adjustment

The Purpose of the IME Adjustment

Since the inception of the Medicare prospective payment system (PPS) in 1983, Congress has recognized that the additional missions of teaching hospitals increase their costs and has supplemented Medicare inpatient payments to teaching hospitals with the indirect medical education (IME) adjustment. The AAMC believes that the IME adjustment is an important equity factor that recognizes the additional roles and costs of teaching hospitals. While its label has led many to believe that this adjustment compensates hospitals solely for graduate medical education, its purpose is much broader. Both the House Ways and Means and the Senate Finance Committees specifically identified the rationale behind the adjustment:

> This adjustment is provided in light of doubts about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents. The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (House

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Ways and Means Committee Report, Number 98-25, March 4, 1983 and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The IME adjustment should not be confused with the Medicare payment for DGME costs. Payments for Medicare's share of the direct costs of graduate medical education programs are separate from the PPS.

Since the inception of the PPS, the IME adjustment has been reduced twice from its original level of 11.59 percent (a reduction of 30 percent), and the executive and legislative branches have proposed further reductions in the level of the IME adjustment. These proposals have been based on calculations using a variety of regression models, more current data, and different combinations of variables. In January 1989 the General Accounting Office (GAO) issued a report that estimated the size of the IME adjustment using various regression specifications and called for a reduction in the level of the adjustment. Every year since 1989, ProPAC has recommended a gradual reduction in the level of the adjustment.

In recent years, however, Congress has indicated that the level of the IME adjustment should reflect the broader mission and overall financial viability of teaching hospitals to assure access and quality of care for Medicare beneficiaries and other patients. Similarly, ProPAC has recognized that the financial success or failure of teaching hospitals could affect access to care and quality of care, and in making its recommendations has tried to assure "rough justice" among hospital groups. "Rough justice" refers to a policy objective of assuring roughly comparable total margins for teaching and non-teaching hospitals.

While PPS operating margins[1] for teaching hospitals are on average higher than those for non-teaching hospitals, teaching hospitals' total margins have remained consistently lower than non-teaching hospitals' total margins. As analyzed by ProPAC in its June 1994 report and shown in Table A below, data from the ninth year of PPS (1992-93), the most complete information publicly available, show that average PPS margins for non-teaching hospitals were minus 6.4 percent, but total margins were plus 4.7 percent. Major teaching hospitals, however, posted PPS operating margins of 8.0 percent, but their average total margins were substantially lower at 3.0 percent. The average total margin for all hospitals was 4.1 percent.

Table A
PPS Operating Margins and Total Margins, by Hospital Group, PPS 9

Hospital Group	PPS Margin	Total Margin
Major Teaching	8.0%	3.0%
Other Teaching	-2.2	4.0
Non-teaching	-6.4	4.7

Source: ProPAC analysis of Medicare Cost Report data from the Health Care Financing Administration.

A more recent ProPAC analysis of preliminary and unpublished data from the tenth year of PPS (1993-94) shows the same relationship between financial margins and teaching status. Major teaching hospitals (hospitals with resident-to-bed ratios over .25) which are underrepresented in the incomplete tenth-year database, had PPS margins of plus 11.2 percent, but recorded average total margins of plus 1.8 percent. Other teaching hospitals (those with IRBs of less than 0.25) had average PPS margins of minus 0.8 percent and total margins of plus 4.4 percent. Non-teaching hospitals had the lowest PPS margins at minus 5.9 percent, but posted the highest total margins at plus 4.8 percent.

The AAMC's Impact Analysis of Reducing the IME Adjustment

The AAMC is greatly concerned that some policy makers have concluded that the IME adjustment could be reduced substantially without threatening the financial viability of teaching hospitals. The AAMC does not agree with this perspective and believes that a reduction of the IME adjustment would seriously undermine the financial stability of teaching hospitals. While a review of FY '94 financial data supplied by 91 hospitals belonging to the AAMC's Council of Teaching Hospitals (COTH) suggests that some teaching hospitals are performing well financially, a closer examination reveals that their total margins have been relatively stable for three years and are comparable to the total margins of non-teaching hospitals. Increases in the average PPS margin have contributed to stable aggregate total margins over the period.

PPS margins for this group of 91 teaching hospitals, all but 19 of which are "major teaching" hospitals, increased in 1994. "Major teaching" hospitals are defined as those having resident-to-bed ratios of 0.25 or greater. Average PPS margins increased from 3.70 percent in 1992 to 11.75 percent in 1994. Of the 91 hospitals, 16 (18 percent) reported lower PPS margins in 1994 than in 1993. While 57 hospitals had negative PPS margins in 1992, only 15 hospitals had PPS margins less than zero in 1994. More importantly, however, the average total margin for this group has remained fairly stable (between 4.60 and 5.12 percent) over the three-year period.

[1] The PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, outlier and "high End Stage Renal Disease (ESRD) cost" payments) less Medicare inpatient operating costs, divided by PPS revenue. The PPS margin definition excludes Medicare revenues and costs associated with capital, direct medical education, PPS exempt patient care units, and some other categories. Because payments for most of these cost components (except capital) are made on a cost reimbursement basis, the margins for these items cannot be positive. Therefore, the margins for Medicare inpatient beneficiaries are less than the PPS margins shown in this analysis.

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Any reduction in the IME adjustment would substantially harm teaching hospitals, destroying the "rough justice" that has been achieved with the current level of the IME adjustment. On average, PPS margins calculated without the IME or DSH payment adjustments, but with only DRG, outlier and "high end stage renal disease (ESRD) use" payments, are minus 31.76 percent. The IME adjustment makes a significant contribution to reducing what would have been large losses, increasing the average PPS margin from minus 31.76 to plus 0.96 percent. The addition of the DSH payment to the margin calculation moves the average PPS margin to plus 11.75 percent. If the IME adjustment is reduced from 7.7 to 5.0 percent, as proposed by the Republican House Budget Committee alternative budget for FY 95, the average PPS margin would fall from a positive 11.75 to a negative 1.49 percent, a reduction of 13.24 percentage points.

Most important, if the IME adjustment were reduced to 5.0 percent, the impact on average total margins would be substantial. The average total margin in 1994 would fall from 5.1 percent to 2.8 percent, a decrease of 2.3 percentage points. At 6.7 percent, ProPAC's recommendation for FY 96, and 4.5 percent IME levels, average total margins would be 4.6 and 3.5 percent, respectively. The calculation assumes no change in the hospital's 1994 intern and resident to bed ratio and no other changes in Medicare payment policy.

Congressional mandates extending Medicaid coverage to broader populations which previously may have been categorized as indigent patients, combined with favorable changes in Medicaid payment policy, may have contributed to these hospitals' improved total margins during this period. However, recently mandated limits on the amount of Federal funding available for Medicaid disproportionate share payments has moderated or will reverse this pattern. In addition, the continued growth in managed care arrangements, which often do not recognize the training and other special costs incurred by teaching hospitals, and pressure by third-party payers to discount high cost tertiary services, threaten teaching hospitals' financial stability.

The IME payment is an important equity factor in the Medicare PPS, compensating teaching hospitals for the higher patient care costs they incur as a result of the severity of their patients' illnesses, the scope of services provided and the impact of educational programs on hospital operating costs. Last year, some policy makers argued that in a reformed health care system in which more individuals would have health insurance coverage and in which all payers would contribute to a fund for patient care costs associated with the academic mission, a significant reduction in Medicare IME payments would be justified. One year later, at the current level of IME payments, "rough justice" appears to have been achieved, but the number of uninsured and under-insured is growing and prospects for the creation of an all payer fund for costs associated with the academic mission are dim.

Teaching institutions are vital national and community resources, often taking care of the most disadvantaged members of society. Yet their overall financial viability, on average, tends to be more precarious than non teaching hospitals. The AAMC has noted repeatedly the purpose of the IME adjustment is to recognize factors that increase costs in teaching hospitals and ensure these hospitals' overall financial viability. Analyses by government and private researchers consistently has shown an empirical basis for a differential payment to teaching hospitals based on their costs. The justification for a special adjustment for these institutions traces back to the Medicare routine cost limits of the late 1970s and the inception of the PPS in 1983. Even if the health care system is reformed to improve access, legitimate cost differences between teaching and non teaching hospitals will continue to exist. Teaching hospitals continue to have higher inpatient operating costs because of the types of patients they treat, services they offer, biomedical research they conduct and residents they teach.

The IME adjustment was originally developed to create a "level playing field" for teaching and non teaching hospitals. It serves as a proxy to adjust for inadequacies in the PPS, including:

- inadequate recognition of differences within a given DRG of the complexity of disease, intensity of care required, and resources utilized by patients in teaching hospitals;
- non recognition of the teaching hospital's costs of maintaining a broader scope of services, staffed by capacity for episodic needs (e.g. trauma services) and the capacity to provide specialized tertiary services;
- failure of the wage adjustment to account for differences between central city and suburban wage rates within metropolitan areas;
- unavoidable decreases in productivity stemming from the presence of physician trainees; and
- additional ancillary services ordered by physician trainees as they learn how to diagnose and treat patients efficiently.

The AAMC strongly supports the importance of considering other factors, such as aggregate financial performance, in addition to an empirical estimate in determining the level of the IME adjustment. Teaching hospitals are under the same budgetary pressures as other hospitals to provide care efficiently; moreover, they must also fulfill their unique educational and service missions, including provision of health care to the poor. The current IME adjustment of 7.7 percent for each 0.1 increase in the number of residents to beds represents a substantial reduction, of over 30 percent, or nearly 4 percentage points, from the original adjustment of 11.59 percent. Teaching hospitals have coped with the decreased rate, but in the current health services delivery environment, they will not be able to withstand further reductions without making substantial changes in the programs and services that they offer.

A reduction in the IME adjustment would hinder teaching hospitals' capability to support adverse selection within the DRGs, high technology care, high cost services for referred patients, and unique community services such as burn and trauma units. The AAMC continues to oppose any reduction in the indirect medical education adjustment and urges the Congress to consider carefully the impact of a reduction in the adjustment on all teaching hospitals.

Average Adjusted Per Capita Cost (AAPCC)

As the delivery system moves toward capitated payments for covered lives, separating the payment for DGME costs and for patient care costs attributable to the special roles of teaching hospitals from patient care revenue becomes necessary. The AAMC believes that the current method of calculating the Medicare AAPCC, the rate that the program pays to risk contractor HMOs, results in a payment system that creates an uneven playing field between teaching and non-teaching hospitals.

The AAPCC calculation includes all Medicare fee-for-service expenditures, specifically the DGME payment, the IME payment and the DSH payment. These payments are intended respectively to compensate hospitals for specific missions (graduate medical education), or for providing services to atypical patients who are severely ill or are of low-income socioeconomic status.

Once these payments have been included in the AAPCC and paid to an HMO, there is no assurance that these dollars are used for the purposes intended by the Congress. Thus, teaching hospitals are at a competitive disadvantage when they attempt to contract with HMOs because the HMOs receive the same AAPCC amount regardless of with whom the HMO has a contract. Teaching hospitals have higher patient care costs associated with their additional missions. The Medicare payment system recognizes these higher costs through the IME and the DSH adjustments and the DGME payment.

ProPAC recently noted this problem in its March 1995 report to the Congress:

> Medicare's capitated payment under its managed care risk contracting program does not appropriately distribute payments for the costs of teaching programs or of caring for a disproportionate share of low-income patients. The capitated rate reflects the extra Medicare payments provided to teaching and disproportionate share hospitals in the fee-for-service sector, regardless of whether Medicare enrollees receive care in those hospitals. The relationship between HMOs and the teaching and disproportionate share hospitals in these service areas warrants further evaluation (pages 7-8).

The AAMC believes that the IME, DSH and DGME payments should be excluded from the calculation of the risk payment rates and paid to a teaching hospital directly when the Medicare HMO enrollee actually incurs a bed day in the teaching facility. Simply put, if the teaching hospital provides the service, it should receive the IME, DSH and/or DGME payments directly whether the service is provided to Medicare beneficiaries under the prospective payment system or through HMOs with risk contracts.

The AAMC urges the Congress to address this methodological issue in an urgent manner as part of its package of proposals to reform the Medicare program. The Association recognizes that while this problem is more prevalent in some parts of the country than in others, it will be increasingly difficult to resolve as national enrollment in Medicare risk based HMOs grows. In addition, the Congress should require ProPAC, as part of its analysis, to develop a methodology for removing these costs from the calculation of the AAPCC and for paying them directly to teaching hospitals when services are delivered to Medicare HMO patients. The Association is pleased that ProPAC has started to analyze how the Medicare program pays risk contractors and the deficiencies of the AAPCC methodology. The AAMC believes that modifying the AAPCC calculation would at least partially ameliorate the competitive disadvantage that teaching hospitals bring to the negotiating table, remove barriers to expanding HMO use among Medicare beneficiaries and strengthen the existing, risk-based coordinated care program.

Conclusion

The AAMC regrets that the possibility of establishing all-payer funds for the special missions of teaching hospitals and medical schools apparently has diminished in the past year. At the same time, all evidence indicates that the health care delivery system will continue to emphasize price competition, challenging the financial viability of teaching hospitals and teaching physicians. The AAMC is deeply concerned that the fundamental structural changes now occurring in the health delivery system will undermine the ability of academic medicine to adapt to the new environment and to fulfill its unique missions.

Academic medicine consists of a diverse group of highly complex institutions providing the environment and resources for medical education and research for the nation and providing both basic and tertiary patient care services. The current emphasis on re-examining national policies in light of limited public resources places these institutions and their vital activities at risk if their special roles and nature are not appreciated.

National policy on health care delivery and payment must recognize the unique characteristics and diversity of teaching hospitals and teaching physicians so that their fundamental missions can be preserved. Reductions in Medicare payments to teaching hospitals and teaching physicians will undermine the ability of these institutions to fulfill their multiple responsibilities at the same time they are struggling to adapt to a new delivery environment. Academic medicine supports those changes that assure the provision of high quality health care in a cost effective delivery system, a vibrant research capability and the capacity to educate outstanding practitioners. Academic institutions need the understanding and support of society to fulfill their obligations. The AAMC looks forward to working with the members of the committee and their staff to meet these common goals.

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Mr. CHRISTENSEN [presiding]. Thank you, Mr. Munson. And Dr. Jacott

STATEMENT OF WILLIAM E. JACOTT, M.D., UNIVERSITY OF MINNESOTA, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. JACOTT. Good afternoon, Mr. Chairman. I am William Jacott. I am a family physician, and I am associate provost for the academic health center at the University of Minnesota in Minneapolis. Today, however, I am speaking as a trustee of the American Medical Association.

As we have learned by the discussion this morning, graduate medical education is really a complex system. Any discussion of GME involves those issues such as the physician work force planning, quality of care, charity care, and specialty choice. I will focus today, however, on financing mechanisms that you, as a committee, will be examining. I want to offer you a structure for analyzing this complex issue. I will discuss several principles that the AMA has endorsed and a suggested first step for implementation. These and other guiding principles are further elaborated in our written testimony.

There are no easy answers here, but there is one overriding goal—for Americans to be confident about the training and education that their physicians receive. But to do this, we must ensure stability and accountability in funding of graduate medical education.

Our first principle, one mentioned earlier and several times, is that all third-party payers should pay their fair share for GME. That is all third-party payers, private as well as public.

You have heard in testimony earlier today about direct and indirect payments to hospitals and especially to those large tertiary care institutions affiliated with medical schools like ours at the University of Minnesota. Right now, Medicare is the single largest payer for GME. It pays about half of the total cost.

Private third-party payers often do not pay their fair share to support graduate medical education, education from which they continue to profit. Hospitals negotiate discount contracts with certain private third-party payers and they do this to maintain their market share. But because these contracts rarely include provision for paying a share of the hospital's GME cost, the costs get shifted. The discount contractor provides no GME support, but benefits from medical resident service.

The AMA believes that there should be some kind of accountability and fairness here. We think that there should be explicit and uniform contributions from all payers for GME. And one way to do this is to require all payers to adopt an approach that is similar to the Medicare methodology for determining their share of the direct costs of GME.

Our second principle: We should continue the current system of linking GME payments to patient care services. Many GME programs are moving to alternative sites for delivery of care and education. We ought to have the payments in those cases follow the patients and the resident physician who is providing that patient's care. And that means if the patient gets his or her care at an am-

bulatory clinic or a nursing home or a rural health clinic, then that facility should receive the payment.

This has the further benefit of encouraging physician training in "nontraditional" sites, a subject that was discussed earlier this morning, with decided emphasis on primary care. Physicians in training benefit because they are better prepared to practice in any evolving health care delivery system. Patients benefit because of the increased availability of care.

The National Resident Matching Program just reported on March 15 that over half of medical student seniors have chosen primary care as their initial training. Some of these students, however, may later choose subspecialty training. But it is clear that student choices are responding to the marketplace. And GME training opportunities ought to support these choices.

The AMA recommends that HCFA revise its regulations governing Medicare direct medical education payments to teaching hospitals. There are some wide variations in claim costs, largely due to the imprecise nature of regulations currently governing what direct costs are allowable. More parity in payment needs to be developed. All payers, including Medicare, should be assured that they are paying legitimate GME costs. This accountability is only fair if we expect all payers to contribute their fair share to the costs.

In conclusion, Mr. Chairman, the AMA believes that the changes I have articulated today are warranted in order to control GME costs. We want to stabilize GME funding so we can assure a quality national physician work force for our patients.

We appreciate, with your approval, Mr. Chairman, the opportunity to supply additional comments for the record, and I would be pleased to answer questions.

Thank you.

Mr. CHRISTENSEN. Thank you, Dr. Jacott. Your full testimony will be submitted for the record.

[The prepared statement follows:]

Statement

of the

American Medical Association

to the

Subcommittee on Health
Committee on Ways and Means

U.S. House of Representatives

RE: Financing Graduate Medical Education

William E. Jacott, MD

March 23, 1995

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a family physician, Assistant Vice President for the Academic Health Center at the University of Minnesota, and a member of the Board of Trustees of the American Medical Association (AMA). On behalf of the 300,000 physician and medical student members of the AMA, I'm pleased to have this opportunity to testify regarding issues of graduate medical education (GME) financing and physician workforce planning. My testimony will briefly review how GME is currently financed and some of the problems that have arisen as a result of that financing system. I will then offer guidelines and recommendations developed by the AMA for improving this system while preserving its stability and its essential functions of training medical personnel for future generations.

Background Information

Graduate medical education (GME) is an essential component of the formal education of the physician. Graduates of U.S. medical schools are required to complete at least one year of GME by all jurisdictions before being able to obtain a license to practice, and 2 or 3 years of GME in several jurisdictions. Graduates of foreign medical schools are required to have 3 years of GME by half of the 54 jurisdictions and either 1 or 2 years by the other half. Physicians must successfully complete a GME program accredited by the Accreditation Council for Graduate Medical Education (ACGME) in order to be eligible for certification in one of the specialties of medicine, for which training ranges from a minimum of 3 years to as long as 8 years. Physicians may be licensed, however, without successfully completing all years of an accredited GME program.

During the past two decades, the GME "system" has increased in size and scope. At present, there are some 7,277 individual GME programs conducted in over 1,500 medical facilities. Approximately 1014 institutions, of which 85% are hospitals, sponsor GME programs in one or more of the specialties of medicine. The majority of GME is conducted in large tertiary care hospitals affiliated with the nation's medical schools.

As of 1993, there were 97,300 resident physicians enrolled in ACGME-accredited GME programs in this country. Approximately 74% of those resident physicians were graduates of U.S. or Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME); 3% were graduates of U.S. osteopathic schools; and 23% were graduates of foreign medical schools not accredited by the LCME. Almost one third of the total resident physicians on duty were enrolled in approved residencies in internal medicine or internal medicine subspecialties. And, as reported as recently as March 15th, 1995, by the National Resident Matching Program, this year more than half of U.S. medical student seniors have signed up for initial residency training in primary care -- that is, in family practice, internal medicine and pediatrics. While some of these students will continue to enter subspecialty training, it is clear that student choices are responding to the changing marketplace.

The responsibility for the oversight of this large and extremely important educational enterprise is widely diffused. GME program directors, hospital service chiefs, medical school department chairs, and the administrators of medical facilities currently have a great deal of autonomy in determining the size and mix of the GME programs sponsored by a given facility. The ACGME is responsible for establishing accreditation standards in the approved residency training programs and accrediting individual GME programs. Individual Residency Review Committees (RRCs), which are composed of representatives appointed upon nomination by the AMA, the appropriate specialty board, and, in a majority of cases, a specialty society, are responsible for assuring these standards are met.

GME Financing

GME is largely financed from patient care revenues generated by teaching hospitals. Medicare is the only third party payer that reimburses hospitals separately for GME costs. Although Blue Cross plans and commercial insurance companies generally recognize that GME costs are built into the rates they pay teaching hospitals, they do not require that these costs be explicitly identified for separate reimbursement. Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and self-insured industry or government plans are generally unconcerned about the individual components of provider costs, particularly GME costs, as long as they are able to obtain competitive prices by negotiating discounts from stated charges. With the exception of Medicare, there is no way to document precisely the actual contribution that each payer whose beneficiaries use the services of resident physicians in teaching hospitals makes to the financing of an institution's GME costs. It is reasonable to conclude, in fact, that a significant portion of HMOs, PPOs, and self-insured plans do not contribute to the financing of GME.

The federal government is the single largest contributor to the total costs of GME in the country. The Medicare program pays approximately 30% of the direct costs of GME in non-federal teaching hospitals. The Department of Veterans Affairs (VA) and Armed Forces finance GME programs operated in VA and military hospitals. These federal hospitals sponsor approximately 10% of all GME positions in the country. Through grants provided under Title VII of the Public Health Services Act, the federal government also subsidizes some of the costs of GME programs in family medicine, general internal medicine, and general pediatrics. Finally, the federal government provides an additional contribution to the

The AMA also recognizes Obstetrics-Gynecology as a primary care specialty.

financing of GME costs of non-federal hospitals to the degree that state Medicaid programs actually contribute to the financing of GME costs. Although exact figures are hard to obtain, the federal government, in the aggregate, finances approximately one-half of the total direct costs of GME in the country.

The methods of financing GME largely dictate the current nature of the GME system. As noted above, the great majority of GME costs are financed from hospitals' patient care revenues; thus, programs tend to be hospital-based. Over the years, the allocation of these funds has been heavily influenced by program directors, service chiefs, and department chairs, who have been primarily interested in providing resident physician coverage for increasingly specialized inpatient services. As a result, the GME system became heavily oriented toward inpatient-based, highly specialized training in tertiary care institutions. The current methods of financing GME have made it difficult to establish primary care GME programs in settings other than hospitals, such as non-hospital based ambulatory settings and rural health clinics.

Improving GME Financing

During the past decade, government concerns about the long-term financial integrity of the Medicare program and attendant changes in the financing of health care in both the private and public sectors have focused a great deal of attention on the financing of GME. The sequence of events that led to this situation reveals the compelling reasons for reform in GME financing. In 1983, the Congress, prompted by the need to control the rate of growth in Medicare expenditures, reformed Medicare policies governing Part A payment to hospitals and introduced the Diagnostic Related Groups-based Prospective Payment System (PPS). In constructing the DRG payment methodology, the Congress specifically excluded the costs of GME from the calculation of the DRG payments. Under PPS, teaching hospitals received a separate payment, the Direct Medical Education (DME) payment, to cover Medicare's share of the institution's medical education program costs. It should be noted that the DME includes not only the costs of GME, but also the costs of nursing and allied health education programs. With respect to GME, hospitals are allowed to claim costs in three major categories -- the salaries and benefits paid to resident physicians, salaries paid to faculty for supervising resident physicians and administering GME programs, and general overhead allocated to GME programs. There is great variation in the costs claimed by individual teaching institutions for DME, and this is largely attributable to the accounting method used to determine GME costs. Although Medicare's standard cost reporting methodology is still used to calculate an institution's medical education costs and the amount of the DME, the 1985 Comprehensive Omnibus Budget Reconciliation Act (COBRA) modified the payment methodology to limit payment for GME costs. Under these new rules, the GME payment amount cannot exceed, on a resident full-time-equivalent (FTE) basis, an institution's FTE amount for FY 84, corrected for inflation.

In addition to the DME payment, teaching hospitals also receive a second payment -- the Indirect Medical Education Adjustment (IMEA) -- not received by nonteaching institutions. Although many analysts have treated the IMEA as though it were solely due to the costs of medical education, this is not the case. When introducing the PPS, the Congress stated clearly that the IMEA was intended (1) to serve as a proxy for an intensity-of-illness factor that could not be incorporated into the DRG payment and (2) to cover the costs of medical education that could not otherwise be identified and included in the DME. The academic

community has acknowledged that the IMEA is not in any way an educational adjustment equivalent to the DME.

Medicare's new payment methodology for physician services, the Resource-Based Relative Value Scale (RBRVS), has had an important impact on discussions of GME financing for several reasons. First, because the IMEA payments were explicitly identified, Congress was able to determine for the first time Medicare's contribution to financing the total costs of medical education conducted in teaching hospitals. Second, by mistakenly identifying the IMEA as though it was dedicated only to medical education costs, Medicare's contribution to financing these costs was exaggerated. As a result, RBRVS has had the effect of making medical education costs, particularly GME costs, a highly visible target for those seeking ways to control Medicare expenditures without seeming to cut services to beneficiaries.

Those interested in decreasing the amount Medicare pays for GME have justified their position by referring to the language of the original Medicare legislation. In the body of the legislation, Congress stated that the costs of the services provided by interns and resident physicians could be claimed by hospitals as a legitimate inpatient expense. However, no mention was made of the many other costs associated with medical education programs. In the Conference Report accompanying the legislation, Congress acknowledged that hospitals incurred additional expenses by sponsoring medical education programs, but stated that Medicare should pay its fair share of those costs only until the community developed an alternative way of paying those costs.

The Social Security Advisory Council (in 1982), the Inspector General of the Department of Health and Human Services (in 1984) and officials of the Health Care Financing Administration (in 1985) have all stated that sufficient time has passed for alternative sources of funds to be identified to cover GME costs. To date, however, Congress has rejected the notion that Medicare should discontinue paying GME costs. At the same time, Congress has expressed concern that the policies governing Medicare payment for GME may be no longer appropriate and should be examined.

Coincident with the introduction of the Prospective Payment System (PPS), major changes also occurred in the financing of health care services in the private sector. Due in large part to the continued growth of aggregate health care costs, businesses and other third party payors have developed more aggressive strategies for controlling their own expenditures for health care. Central to these strategies are efforts to negotiate discounts in the prices providers are paid for delivering services to plan beneficiaries. In order to maintain market share in this increasingly competitive environment, hospital administrators have been willing to provide discounts, even though doing so has clearly eroded their operating margins. Since GME had been largely financed from hospitals' discretionary revenues, the narrowing operating margins have been perceived as a threat to the continued financing of GME costs.

In its report, "The Financial Status of Teaching Hospitals: The Underrepresentation of Minorities in Medicine" (1990), the Council on Graduate Medical Education (COGME) documented the declining operating margins of the nation's teaching hospitals. However, the data presented in the report clearly demonstrate that this decline is due primarily to a decline in non-Medicare revenue margins. The decline in non-Medicare revenue margins is due largely to two factors: (1) deep discounts negotiated with some payors, and (2) the growing uncompensated care burden being borne by teaching hospitals. Nevertheless, and this is particularly important, teaching hospitals have generally done better than non-teaching

hospitals under PPS, primarily because of the Medicare IME payments received by teaching institutions which have been used to offset these costs.

Rational reform of GME financing will occur only if there is constructive dialogue on important GME issues among members of the medical profession, government officials, and representatives of business and the insurance industry. The AMA would like to use this opportunity to articulate overall goals for GME financing reform and propose a set of principles that can serve as a framework to guide discussions of GME financing reform.

Goals

The AMA believes that reform should achieve long-term stable funding of GME to ensure that all graduates of U.S. medical schools will be able to obtain, at the very least, GME leading to eligibility for initial board certification and result in increased accountability for the total number and specialty mix of GME positions, the appropriateness of the site of GME training, and the appropriateness of both the content and length of training requirements.

The AMA believes that these goals can best be achieved if discussions of GME financing reform are guided by the following set of principles:

Principle #1 — All third-party payors should participate explicitly and in a uniform way in the financing of GME.

Principle #2 — The financing of GME should continue to be linked to the financing of patient care services and payments should accrue to the actual facility providing those services.

Principle #3 — Efforts to reform GME financing should focus primarily on the methods of financing the direct costs of GME, with any changes in IME/A phased in gradually so that alternate sources of funding can be identified.

Principle #4 — The Health Care Financing Administration should revise the regulations governing Medicare DME payments to eliminate some of the variation in GME costs claimed by teaching hospitals.

Principle #5 — The procedures used by the ACGME RRC's and the Specialty Boards for adding new specialties and those for extending the length of training required for certification in existing specialties should be reviewed.

Discussion

Principle #1

The AMA believes strongly that all third party payors should participate explicitly in the financing of GME in order to ensure stable funding for GME into the future. We also believe that there should be a uniform system across the country for contributing to GME financing. Medicare is at present the single largest payor for GME and has a methodology in place for identifying an institution's total direct GME costs. Accordingly, the AMA recommends that all payors be required to adopt the Medicare approach for determining their

share of the direct costs of GME. We recognize that an all-payor system for financing GME was a controversial issue argued in the context of comprehensive health system reform last year. But it is equally clear that private payors are not paying their fair share to support a system from which they continue to profit.

It may be virtually impossible to develop mechanisms ensuring that all payors contribute to GME as long as individual teaching hospitals are free to negotiate payments for patient care services with individual payors without any restrictions. As a means of maintaining "market share," teaching hospital executives have demonstrated a willingness to provide discounts to certain payors, with the consequence of diminishing -- sometimes quite significantly -- the institutions' operating margins. Given past experience, it is difficult to believe that teaching hospital executives would be willing to voluntarily negotiate separate GME payments or allow a portion of their negotiated payment to be designated for GME in order to comply with this principle. Accordingly, we believe that a new approach to financing GME is needed.

Medicare could make its participation in GME financing to individual hospitals contingent upon the participation of all payors whose beneficiaries are hospitalized in teaching hospitals. This approach would place on teaching hospital executives the responsibility for obtaining from various payors their agreement to participate in GME financing as a condition of having their beneficiaries use the services of the institution. Since the Medicare methodology would be used to calculate each payor's fair share of the institutions' GME costs, there would be no requirement for prolonged negotiations on the terms of the payment.

Principle #2

Before reaching the conclusion that the financing of GME should continue to be linked to the financing of patient care services, the AMA considered the proposals advanced in recent years that alternative sources of funds should be identified to cover GME costs. The interest in identifying alternative sources of GME funding can be traced directly to concerns about the continued use of Medicare Part A Trust Funds to pay medical education costs. The most frequently mentioned alternative sources of funds that might be available to finance GME include general tax revenues, medical school budgets, and faculty practice plans. The AMA believes strongly that GME costs should continue to be paid from revenues intended to cover the costs of patient care services.

This recommendation is based on the fact that surveys of resident physician activities have shown that resident physicians spend approximately "5% of their time involved in direct patient care activities. Resident physicians undoubtedly provide some services that would otherwise be provided by the patients' attending physicians. In these cases, the resident physician is acting as a surrogate for the supervising attending physician who bills for these services. The attending physician, in return, supervises the resident physician's education. This quid pro quo arrangement is perfectly appropriate as long as the attending physician is not also compensated by the hospital for supervising the resident physician's education (see Principle #4). However, resident physicians also conduct patient care activities that supplement those that would normally be provided by attending physicians. It is appropriate to pay for the services of resident physicians.

Some commentators have suggested that resident physician salaries should be eliminated and that resident physicians, because of the educational nature of their training, should pay tuition.

to cover the other direct GME costs. Others have suggested that resident physicians should generate their own income by billing for their services. The AMA also rejects these arguments. Resident physicians act in the capacity of advanced graduate students and should be treated accordingly. Under many circumstances, graduate students receive a stipend and their tuition is waived if they provide services as a teaching or research assistant. Since most resident physicians provide patient care services and teach medical students and other resident physicians, it is appropriate that they receive a stipend and not pay tuition to the teaching institutions with which they are affiliated. Such a mechanism would raise the total costs of medical education, leading to rising debt loads for young physicians entering their practices.

Another important point regarding the patient services nexus for payment is that payments for these services should go directly to the facility where the training takes place and where the patient is provided the service. Given current trends, including the delivery of services in ambulatory and primary care settings, and the consequent emphasis on primary care within the GME system, it is absolutely essential that payment accrue to the facility where the patient receives services. The AMA continues to support initiatives to develop new methodologies for the costs incurred in physician training in "non-traditional" sites and encourages medical education to be provided in settings that will best prepare physicians to practice in any evolving health care delivery system (e.g., nursing homes, outpatient surgery or ambulatory care settings, rural settings, and homeless shelter clinics).

Principle #3

While recommending that GME financing reform focus primarily on the methods of financing direct GME costs, we recognize that this is not the only policy issue related to the topic of GME financing. Certainly, the financial viability of major teaching hospitals, particularly those which serve a disproportionate share of uninsured patients, is a legitimate issue for concern. In this regard, the AMA recognizes that teaching hospitals are particularly concerned that Congress might legislate decreases in Medicare IME/A payments and thus further decrease their operating margins. However, as noted previously, the 1990 COGME report documented that recent decreases in hospital operating margins are rooted primarily in decreases in non-Medicare revenue margins. The AMA therefore believes that it is inappropriate to focus attention solely on the Medicare IME/A. The financial status of teaching hospitals will remain unstable as long as hospital administrators continue to grant discounts to certain private payors who do not contribute their fair share to the financing of GME, and until governments develop a more equitable way to cover the costs of uncompensated care.

The AMA believes that efforts to reform GME financing should not be burdened in the immediate debate by attempts to resolve these very complex issues of uncompensated care and the effect of discount contracting on the financial stability of some teaching hospitals. Such an approach would inevitably lead to prolonged discussion that would effectively derail any attempts to deal with the serious problems facing GME.

Principle #4

The AMA strongly supports the principle that HCFA should revise the regulations governing Medicare DME payments to eliminate the extraordinary variation in DME costs that currently exists among teaching hospitals. The variation in claimed costs — as much as a

tenfold difference — can be traced to the imprecise nature of the regulations governing the determination of allowable GME costs. Under existing Medicare regulations, individual teaching hospitals have an inordinate amount of discretion in determining how costs are allocated. Frankly, the degree of variation that exists undermines the credibility of teaching hospitals and the medical profession on GME financing issues. In order to incorporate the Medicare approach for financing GME into an all payor system, the methodology used for claiming GME costs must be refined so that all payors, including Medicare, can be assured that they are paying only legitimate GME costs. This accountability is a fair expectation if we are to expect all payors to contribute fairly to the costs of GME.

In its first report, COGME noted the results of a Congressional Budget Office survey indicating extreme variation in claimed GME costs by teaching hospitals and recommended that this issue be studied in more detail. Further analysis indicates that the variation in GME costs within this group of institutions can be explained primarily by two factors: (1) variations in faculty salary costs, and (2) allocated overhead costs. Within each of these categories, the degree of variation cannot be explained by variation in the size and scope of the institution's GME programs or the nature of the teaching hospital.

During recent years, discussions aimed at determining ways for controlling the total costs of DME have generally assumed that limitations would be placed on the total number of GME positions available in the country. Although ill founded, these discussions have created a certain anxiety about the availability of GME positions for all graduating students of U.S. medical schools. Indeed, in order to avoid this situation, several professional organizations recommended in the mid-1980s that graduates of foreign medical schools be denied access to GME in this country as a means of controlling GME costs. It is now apparent that total GME costs can be decreased without cutting positions--provided that steps are taken to eliminate inappropriate differences in faculty salary costs and allocated overhead costs claimed by some teaching hospitals.

In this context, the AMA recommends that HCFA rewrite existing regulations to define more precisely the faculty salary costs and general overhead costs that may be allocated to GME. More specifically, regulations should be promulgated to limit faculty salary costs to the time faculty are directly involved in the administration of GME programs or in the supervision of resident physicians under circumstances in which no separate bill is submitted for professional services either by the physician or the hospital. Similarly, overhead costs should be limited to those associated with direct support of GME program activities. General overhead costs should not be allocated to GME. As noted previously, all payors should then adopt the Medicare regulations in order to ensure consistency in determining and auditing GME costs and to fairly distribute the shared burden.

We also recommend that annual surveys continue to document the level of salaries and benefits paid to resident physicians in order to ensure that unreasonable variation in salaries does not develop among teaching hospitals. Similarly, annual surveys should be conducted in order to document the variation in faculty and overhead costs among teaching hospitals. This should not be construed to imply that variations are not warranted; sites and needs vary and a St. Paul hospital will not pay the same faculty salaries as will a New York City Hospital. The results of these surveys should be made available to payors who are contributing to the financing of GME.

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Principle #5

In order to prevent inappropriate growth in the number of GME positions, the AMA feels that revisions must be considered in the procedures for adding new specialties and for extending the length of training required for certification in existing specialties. During the 1980s, the number of resident physicians in GME programs increased by greater than 30%. During the same period, the number of U.S. medical school graduates remained fairly constant. We conclude that the marked increase in GME positions was largely due to the proliferation of new specialty residency programs and positions. This trend has clearly increased the costs of GME in this country.

At present, decisions regarding specialty training issues are controlled, for all practical purposes, by the specialty boards and the ACGME. In some cases, changes in training requirements have been initiated by a specialty board, and in some cases, by an RRC. As a body primarily concerned with GME accreditation issues, the ACGME has not been charged with the responsibility of balancing the interests of the specialty oriented organizations with the concerns of government, business, other interested parties, and the public. As a result, the specialty organizations have been free to increase training requirements, thus increasing the costs of GME, without concern as to the impact of their decisions on the system as a whole.

Voluntary accreditation and certification remain an important feature of the GME system in this country. To maintain this important characteristic, interested parties and the public must be assured that there is accountability for the decisions made by the RRCs and the specialty boards. In its first report (1988), COGME recommended that the parent organizations of the ACGME convene to develop specific ways for dealing with this issue. In addition, COGME recommended that the American Board of Medical Specialties bring this issue to the attention of the individual boards. To date, these boards have not dealt with this problem in a satisfactory manner.

Conclusion

The AMA has considered the issues surrounding financing reform in GME and has developed goals and a set of principles to assist the national debate on this issue. The AMA believes that such reform is warranted in order to control the costs of GME, to stabilize the funding of GME, and to improve the accountability of the GME system to society so that national physician workforce objectives are achieved and maintained.

The AMA offers the above articulated principles as guidance to the Subcommittee and Committee in their evaluation of GME financing. We thank the Subcommittee for soliciting our thoughts and recommendations on this highly complex issue of financing graduate medical education. We look forward to working with other affected organizations and hope that we can be a continuing resource as the Subcommittee and full Committee develop their proposals.

Mr. CHRISTENSEN. Dr. Schwartz.

STATEMENT OF SEYMOUR I. SCHWARTZ, M.D., FACS, CHAIRMAN, BOARD OF REGENTS, AMERICAN COLLEGE OF SURGEONS

Dr. SCHWARTZ. Thank you, Mr. Christensen.

I am Dr. Seymour Schwartz. I am professor and chair of the department of surgery at the University of Rochester Medical Center in Rochester, N.Y. I am appearing today as chairman of the board of regents of the American College of Surgeons with its constituency of over 60,000 surgeons.

In that regard, we are pleased to have the opportunity to offer this testimony, and we will focus our remarks on the issues of Medicare payments for direct medical education costs, but also on physician work force requirements and controls.

It is our feeling, strongly so, that the Federal financial support for graduate medical education must continue if our Nation is to maintain its preeminence in producing well-trained, highly qualified physicians.

The College strongly believes that all Federal, and as was stated before, all private health care financing programs should participate in the support of this system.

Reductions in Medicare payments to hospitals and physicians have already been implemented. This has been compounded by continuing payment decreases by private third-party payers and an increasing trend to managed care.

As a consequence, teaching programs have become increasingly dependent on Medicare support, because they are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients.

This is more of a problem for specialties with longer training programs, such as the surgical specialties, which already receive reduced financial support beyond the first 5 years of training.

Proposals have been made to limit Medicare direct graduate medical education support to the first 3 years of residency. I was pleased to hear from Dr. Heyssel that he modified this proposal with respect to the 5-year surgical program.

The College opposes these proposals. It is felt that the specialties with the longest training programs are just as critical to the health care needs of our Nation as those with a shorter program. Also, the quality of programs that train our medical and surgical specialists are as important as the quality of those that train our primary care physicians.

Recent studies have concluded that the physician work force problem is not so much that of undersupply of certain types of physicians as it is of an oversupply of physicians in general. We agree to that, and would also point out that the larger problem is a poor geographic distribution of all categories of physicians.

The College believes that Congress should focus its attention on policies directly aimed at controlling the size and specialty mix of our Nation's physician work force, rather than on indirect efforts to achieve these goals through mechanisms of program financing. We also feel that such policies hold the promise of reducing total Medicare spending for direct graduate medical education.

We also agree that broad goals should be set regarding the number of generalists and specialists to be trained, but would emphasize that quality should be the major determinant in deciding which residency programs should be funded and in how residency slots should be allocated.

Actually the number of residency positions in surgical programs is determined specifically by patient mix and volume that ensures that training criteria are met. This has limited the number and the size of surgical training programs. The number of physicians trained in surgical specialties has remained relatively constant over the past decade. In the academic year of 1982 to 1983, there were 21,000 residents cumulatively in all surgical specialties. About 10 years later, 1992 to 1993, the most recent year for which data are available, this number is essentially the same.

Now I would like to emphasize that in general surgery for the same period, the number has decreased steadily from 8,683 to 7,788.

There is a growing sentiment in the medical community that the number of residents should be constrained. However, Federal physician work force controls may be viewed by some as not in concert with the current efforts to reduce bureaucracy.

We would submit that a mechanism is in place. That mechanism is the residency review committees for the various specialties. They are encumbered at this time by the feeling that they do not have the authority or the antitrust immunity required to impose limits.

We would suggest Federal endorsement of the residency review committees as the body to address the issue of numbers.

I would point out that even if we accept the physician work force controls as a possible solution, they in no way address the persistent geographic maldistribution of physicians. And as has been pointed out several times already, it seems that current marketplace pressures may be playing a positive role in alleviating or correcting this situation.

In Southern California, for instance, medical and surgical specialists are finding that there are simply not enough patients to maintain their practices, and some of these are relocating to smaller and at times rural communities. Some have even become primary care physicians.

Mr. Chairman, on behalf of the College, I would like to thank you for the opportunity to express our views on these issues. I would be pleased to answer any questions.

[The prepared statement and attachment follow:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

presented by

Seymour I. Schwartz, MD, FACS
Chairman, Board of Regents

RE: Graduate Medical Education

March 23, 1995

Mr. Chairman and members of the Subcommittee, I am Seymour I. Schwartz, MD, FACS, Chairman of the Board of Regents of the American College of Surgeons, and Professor and Chairman of the Department of Surgery at the University of Rochester Medical Center in Rochester, NY. I am pleased to appear here today on behalf of the College to provide our views on Medicare funding for graduate medical education. In particular, I intend to focus my remarks on the issues of Medicare payment for direct medical education costs and on physician workforce requirements and controls.

First of all, I want to stress that federal financial support for graduate medical education must continue if our nation is to maintain its world preeminence in producing well trained and highly qualified physicians. Further, the College strongly believes that all federal and private health care financing programs should fully support this system. We are very concerned, for example, about reports that Medicare HMOs may not be passing on to teaching institutions the federal funds they receive to support graduate medical education.

We are aware, of course, of the budgetary pressures that Congress has faced in recent years and the reasons why entitlement programs like Medicare make attractive targets for spending reductions. However, you should be aware that, because of reductions already implemented in Medicare payments to hospitals and physicians, compounded by continuing payment decreases by private third-party payers and the increasing trend toward managed care, teaching programs are becoming even more dependent on Medicare financial support and are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients. This a particular problem for those specialties with longer training periods, such as the surgical specialties, which already receive reduced financial support from Medicare beyond the first five years of training.

Proposals have been made that would further limit Medicare direct graduate medical education support to just the first three or four years of residency training. The College opposes such proposals. Generalist physicians can not meet all of our nation's health care needs. Those specialties with the longest training periods -- such as neurosurgery, which typically includes seven years of residency training -- are just as critical to the health care needs of our nation as those with the shortest residency training. Furthermore, the quality of programs that train our nation's medical and surgical specialists is as important as the quality of those that train our primary care physicians; both types of programs should be funded for their full residency periods.

In an effort to increase the supply of primary care physicians, proposals have also been made that would use money saved by limiting Medicare support for specialties with longer training programs to increase the amount provided to primary care residency programs. As we have noted in past testimony, the College has long doubted that paying hospitals more to establish primary care residency positions will do anything to influence the

career choices made by individual medical students. In addition, many residency positions in primary care training programs go unfilled year after year. It makes little sense for a Congress that is concerned about budget savings to increase federal funding to encourage hospitals to establish yet more residency positions that are likely to remain unfilled.

Indeed, recent studies of the nation's physician workforce have concluded that our problem is not so much an undersupply of certain kinds of physicians as it is an oversupply of physicians in general, as well as a poor geographic distribution of physicians. (A paper is attached that more fully outlines some of the issues associated with policies directed at increasing the supply of primary care physicians.) It is the College's view that Congress should focus its attention on policies that are directly aimed at controlling the size and specialty mix of our nation's physician workforce, rather than on indirect efforts to achieve these goals through program financing mechanisms. Such policies also hold promise for reducing total Medicare spending for direct graduate medical education costs.

The College agrees with proposals that have been made that would limit the total number of physicians being trained, perhaps to 110 percent of U.S. medical school graduates. We also agree that broad goals should be set regarding the number of generalists and specialists to be trained. We do believe strongly, however, that quality should be the major factor in determining which residency training programs will be funded and how actual residency slots will be allocated among each specialty.

In the surgical specialties, the number of individuals being trained has been restrained by such quality considerations for many years. No surgical training program can add new residency positions unless patient mix and volume assure that specific training criteria are met. This limits both the number and the size of surgical training programs. In addition, smaller training programs with relatively few residents are held to the same high standards as larger programs.

In fact, the number of physicians trained in the surgical specialties has remained relatively constant for more than a decade. In the 1982-83 academic year, there were 21,133 residents across all the surgical specialties; in 1992-93, the most recent year for which complete data are available, there were 20,976. In general surgery, the number has actually decreased steadily, from 8,683 in 1982-83, to 7,788 in 1992-93. Further, it is worth noting that the total number of surgeons being trained each year in some specialties is actually quite small (e.g., 53 in colon and rectal surgery, 39 in pediatric surgery, and 89 in vascular surgery in 1992-93).

Of course, there is a regulatory overtone to the idea of federal physician workforce controls that may not appeal to some policymakers. However, while there is growing sentiment in the medical community that the number of residents should be constrained in some way, there is also a general belief that antitrust laws preclude physicians from establishing and imposing any limits on their own initiative. The residency review committees for the various specialties and the Accreditation Council on Graduate Medical Education believe that they do not have the authority or the antitrust immunity needed to impose such limits. A federal mandate to do so would address some of these concerns.

It is worth noting that Congress has often established commissions and supported studies of our nation's physician workforce, but it has never given these entities the authority to implement any workforce policies based on their findings.

Of course, while physician workforce controls are a possible solution to problems involving overall physician supply and specialty mix, they do not address the persistent geographic maldistribution of physicians. As you know, federal efforts to address this problem have met with limited success. However, it now appears that market pressures may indeed hold some promise for alleviating, if not completely correcting, this situation. Many medical and surgical specialists located in areas where managed care has become a dominant market force, such as southern California, are finding that there simply are not enough patients available for them to maintain their practices. As a result, we are hearing

that quite a few of these specialists are relocating to smaller communities, often in more rural states. Many of them have also assumed the role of primary care physicians.

Mr. Chairman, thank you again for the opportunity to express our views on these issues. I would be pleased to answer any questions you may have.

American College of Surgeons

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PRIMARY CARE: HAVE POLICY MAKERS GONE TOO FAR?

Issue

Over the last several years, the federal governmental has implemented a number of policies and programs intended to increase the supply of primary care practitioners, including increases in Medicare payments for primary care services, such as physician office visits. In many cases, these initiatives have come at the expense of other programs and other categories of health professionals and services. Some physicians' organizations continue to demand more for primary care. However, there is evidence that further increases in the number of primary care physicians could lead to an oversupply. At the very least, Congress should carefully consider whether it is fair to support any additional primary care initiatives by arbitrarily reducing payments to other physicians or reducing funds for other programs.

Key Things to Keep in Mind

1. **The Potential for "Overkill".** The federal government has adopted Medicare reimbursement policies favoring primary care residency programs. And, there is continuing discussion of adopting policies that would assure that 50 percent or more of all residency positions are allocated to primary care. However, a recent study published in the Journal of the American Medical Association concluded that "a change as great as the 50 percent solution will cause a long-term surplus of primary care physicians and a long-term shortage of specialists."[1]

2. **Medicare Beneficiary Need for Specialty Care.** The federal government has adopted a number of provisions to increase Medicare payments to primary care physicians (e.g., the relative value system, preferential updates, and exemptions from various cost-containment policies). However, it seems likely that Medicare beneficiaries, given their age and health status, may well need greater amounts of specialty care than the non-Medicare population. For example, a recent study published in the New England Journal of Medicine found that "Internists and family practitioners are less aware of or less certain

[1] Richard A. Cooper, "Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-686.

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about key advances in the treatment of myocardial infarction than are cardiologists."[2] In fiscal year 1993, there were almost 310,000 Medicare hospital admissions for the treatment of myocardial infarctions.

3. **Impact of Non-Physician Primary Care Providers.** The federal government has simultaneously adopted policies to increase the supply of primary care physicians and the supply of non-physician primary care practitioners, including physician assistantsand advanced practice nurses. Those recommending further increases in the supply of primary care physicians generally fail to take into account the capabilities and contributions of a rapidly increasing supply of non-physician primary care providers. Moreover, in determining the number of so-called primary care shortage areas, the government itself fails to take into account the availability of physician assistants, nurse practitioners, and other qualified providers of primary care. This may explain why the Task Force on Human Resources for Health of the Association of Academic Health Centers has recommended that the Secretary of Health and Human Services convene a special Advisory Council to assess, among other things, "whether primary care shortage criteria should take into account the availability of non-physician personnel.[3] In any event, given the fact that past government policies are at least partially responsible for today's oversupply of physicians, it seems quite likely that the government will again overshoot the mark if it continues to adopt programs favoring primary care.

4. **Lessons from Managed Care.** Policymakers have repeatedly been told to use the physician staffing practices of health maintenance organizations (HMOs) and other managed care organizations as a guide to the population's need for specialist and primary care physicians. However, as one study has warned, "HMO patients tend to be younger and healthier" and "HMO physicians provide only a portion of the specialty care."[4] Moreover, another recently published study found that seven Kaiser HMO plans and three other large HMOs had primary care physician-to-population ratios of 53.6 and 35.7 per 100,000 enrollees, respectively, compared to the nation's current primary care physician supply of 65.7 primary care physicians per 100,000 population.[5]

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[2] John Z. Ayanian et al., "Knowledge and Practices of Generalist and Specialist Physicians Regarding Drug Therapy for Acute Myocardial Infarction," New England Journal of Medicine, October 27, 1994, pp. 1136-1141.

[3] Association of Academic Health Centers, Task Force on Human Resources for Health, "Avoiding the Next Crisis in Health Care," 1992, p. 21

[4] Richard A. Cooper, "Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-687.

[5] Jonathan Weiner, "Forecasting the Effects of Health Reform on U.S. Physician Workforce Requirement: Evidence From HMO Staffing Patterns," Journal of the American Medical Association, July 20, 1994, pp. 222-230.

5. **International Comparisons.** The average American must, by now, believe that the primary care physician-to-population ratios in the United States are considerably below those in other countries frequently held up as having model health care systems. However, as emphasized in a study by U.S. and British researchers published in the New England Journal of Medicine, the ratio of primary care physicians to the general population is the same in the United States and the United Kingdom. A more recent study notes that "the percentage of physicians in the United States who practice one of the primary care disciplines is 36 percent to 38 percent, values quite similar to those in Europe."[6]

6. **Trends in Surgical Residency Positions.** The tone and temper of recent discussions about physician residency programs might prompt some policymakers to conclude that the number of surgical residencies must be rising dramatically. The fact is the number of surgical residents has been quite stable for many years. For example, in the 1982/83 academic year, there were 21,133 surgical residents while, by 1992/93, the number had actually fallen to 20,976.

7. **Non-Primary Care Shortages.** Some policymakers may have been led to believe that the only physician "supply" problems are in the primary care arena. However, the advisory body charged with reviewing physician supply and demand issues, the Council on Graduate Medical Education, has specifically concluded otherwise. For example, the Council has noted that shortages exist in general surgery and warned that "[a]ging of the U.S. population will increase demand for surgical services, and the number of physicians in general surgery is inadequate to meet a growing need for trauma services and for surgical care in rural areas."[7]

8. **Medicare Support for Surgical Residency Programs.** The American College of Surgeons supports the concept of limiting the number of physician residency positions and setting broad goals regarding the number of generalists to be trained. However, the College insists that any mechanism for addressing physician supply issues must explicitly include a policy of adequate funding for all residency positions through the entire course of the training period. As it stands now, Medicare generally pays less than its share of the costs of training surgical residents, primarily because the program limits funding to a maximum of five years, which is shorter than the amount of time required to train most surgeons.

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[6] Richard A. Cooper, Seeking a Balanced Physician Workforce for the 21st Century," Journal of the American Medical Association, September 7, 1994, pp. 680-687.

[7] Council on Graduate Medical Education, Improving Access to Health Care Through Physician Workforce Reform: Directions for the 21st Century, October 1992, p. 22.

Mrs. JOHNSON OF CONNECTICUT [presiding]. Thank you, Dr. Schwartz.

Dr. Anderson.

STATEMENT OF WILLIAM G. ANDERSON, D.O., PRESIDENT, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. ANDERSON. Madam Chair, thank you very much for the opportunity to appear before the Subcommittee on Health.

My name is William Anderson, and I am president of the American Osteopathic Association. I have been practicing as an osteopathic physician for over 38 years in primary care in Southwest Georgia and in recent years as a surgeon in inner-city Detroit.

I am pleased to be here representing 36,000 osteopathic physicians, the majority of whom are in primary care and, we believe, are playing a very vital role in health care delivery in the United States today.

So we feel as though it is very important that members of the subcommittee take under consideration, when we speak of funding of graduate medical education, preserving this system of training osteopathic physicians that has demonstrated historically that it can produce a higher percentage of primary care physicians. As many as 60 percent of the 36,000 are currently in the primary care specialties.

So before I go to some specific recommendations relative to this matter of training relevant physicians and cost containment in graduate medical education, I wanted to just make a few brief remarks relative to the profession itself.

Osteopathic physicians are trained in many respects the same as allopathic physicians in that we have the same basic training in medicine, surgery, physiology, anatomy, and all the fundamentals. However, osteopathic physicians have the added dimension where emphasis is placed on the musculoskeletal system and the body functioning as a whole with an interrelationship between structure and function.

This philosophy of practice was first initiated by Andrew Taylor Still over 100 years ago, and it permeates our educational process from undergraduate through the graduate levels.

Although a number of osteopathic physicians ultimately go into the specialties and the subspecialties, they all are first trained in primary care. They have that orientation, and it is embedded in them in the rotating internship. We believe that this enables them to practice better even as specialists. So I certainly prevail upon the committee to take under consideration those measures that will be necessary to preserve this system of training.

Now let me go then directly to the matter of how we can achieve savings in graduate medical education while preserving the system and, second, addressing the issues of the physician work force.

First, let me mention the matter of the allocation of the GME positions. We certainly do support the concept that the number of residency positions could be limited to just 110 percent of the total graduates from the osteopathic and allopathic medical schools in the United States.

At the present time, we receive funding from various sources—and the Federal Government through Medicare is the principal

source of that funding—we are funding the equivalent of 140 percent, and we recognize that many of those are the international medical graduates that make up the difference between the 100 percent and the 140 percent.

We feel that if we are in a situation now where we are graduating as many as we need—and there are those who think we are even graduating more than we need—it seems to be just prudent, then, that we should buy what we need to meet the needs of the citizens of this country first.

Then if we have a system that produces enough physicians, it seems to me we should limit our funding to just meeting that need.

So I would strongly recommend that consideration be given to limiting the funding to 110 percent of our graduates.

Now there is a potential for the loss of osteopathic graduate medical education positions if the osteopathic allocation then is buried within a single allopathically dominated pool; therefore, I would prevail upon you to take under consideration the fact that there is a separate system of educating physicians.

Second, GME funding should be equitable for all positions and based on national averages rather than the current system that is hospital-specific, that provides for a wide range of costs in graduate medical education, that may be producing the same end product.

Third, GME funding should be by all third-party payers, and you have heard that repeatedly this morning, and we in the osteopathic profession want to reinforce our position relative to that.

We feel as though all of the third-party payers should participate by funding graduate medical education, recognizing that as managed care now is permeating the medical market and soon will include many of the people who are in the Medicare program, and while the HMOs are receiving 95 percent of that average cost per Medicare patient, and that includes the medical education portion, we feel as though they should bear a portion of that cost, or that portion of the payment to the managed care systems should be removed, so it can go directly to those training institutions.

Fourth, we feel as though there should be a freeze at least on the resident-to-hospital-bed ratio at the current level. This would remove the disincentive to move much of the graduate medical education out of the hospital and into the ambulatory sites. That is less costly than the hospitals. You do not begin to incur as much of an indirect medical cost where training takes place in the ambulatory sites.

If the greater need is for primary care physicians who will practice in ambulatory sites, we feel as though that is where they should receive their training.

In conclusion, osteopathic physicians have provided for many years a vital component in the health care delivery system in America. In order to assist the country in meeting the many challenges in physician work'force development and reducing cost, we suggest that the present system of funding graduate medical education be made more equitable. All residents, without regard to the site of their training, should receive the same direct funding. The indirect funds would be based on averaging, utilizing the same national average, not hospital-specific, and based on a more recent

year basis. Most of us now are operating on the basis of a 1984 base year funding methodology adjusted for inflation.

We do believe that this reimbursement system for graduate medical education does not take into account the demands that are now placed on the educational system in the development of consortia and in the process of paying for the educators.

We certainly would encourage you to consider the 110-percent cap. Simply cutting the payments will not facilitate the work force change that is desired.

Thank you, Madam Chair, for giving me the opportunity to present the concerns of the American Osteopathic Association.

[The prepared statement follows:]

TESTIMONY OF WILLIAM G. ANDERSON, D.O.
AMERICAN OSTEOPATHIC ASSOCIATION

OSTEOPATHIC GRADUATE MEDICAL EDUCATION

Mr. Chairman and members of the Committee, thank you for inviting the American Osteopathic Association ("AOA") to appear before this hearing. My name is William G. Anderson, DO, and I am the current president of the AOA. I am appearing before you today as the representative of the 36,000 osteopathic physicians practicing in the United States.

The AOA is the national organization for osteopathic medicine. The AOA is involved in nearly every stage of an osteopathic physician's education. The AOA is recognized by the United States Department of Education and the Commission on Recognition of Postsecondary Accreditation as the accrediting agency for osteopathic medical colleges. The AOA also accredits 136 hospitals and health care facilities in 26 states. Such hospital accreditation is recognized by the Department of Health and Human Services. Additionally, the AOA in conjunction with various affiliated organizations, formulates general requirements for graduate medical education (internships and residencies) leading to specialty certification through the AOA's various specialty boards. The AOA also examines and approves osteopathic internship and residency programs in osteopathic and jointly accredited (DO/MD) hospitals. The AOA conducts examinations for specialty certification following the completion of such training. Finally, the AOA administers an extensive program of continuing medical education which is required to maintain AOA membership, specialty certification and licensure in numerous states.

For nearly 40 years, I have practiced osteopathic medicine -- first, as a family physician in Albany, Georgia and later, as a general surgeon in Detroit, Michigan. At present, I am the Associate Director of Medical Education at Detroit Riverview Hospital.

The Osteopathic Medical Profession

While the subject of my address today is graduate medical education in general and osteopathic graduate medical education in particular, I would like to first provide you with some background information on the osteopathic profession. There are two distinct but parallel branches of medical practice in the United States: osteopathic medicine and allopathic medicine.

Osteopathic medical practice, a reform movement in medical care, grew out of concepts developed in 1874 by Andrew Taylor Still, MD. Dr. Still's philosophy of medical care focused on "wellness," preventive medicine and the body's ability to heal itself. Dr. Still studied the attributes of good health so that he could better understand the process of disease. He devised a philosophy which emphasized the unity of all body parts, particularly that of the musculoskeletal system, as a key element of health. The unique osteopathic manipulative treatment grew out of this philosophy. All of these principles -- "wellness," holistic medicine, osteopathic manipulative treatment and an emphasis on family/generalist practice -- have been essential elements of osteopathic medicine for over 100 years.

Today, the majority of physicians in this country are allopathic physicians (MDs); however, doctors of osteopathic medicine (DOs) constitute more than five percent of all physicians practicing in the United States. After years of struggling for acceptance, osteopathic physicians have

secured broad recognition at law[1] and in the courts[2] as equivalent to our allopathic brethren. The DO and MD degrees are the only recognized degrees leading to the unlimited licensure for the practice of complete medicine and surgery. Despite our success, there still remain some isolated pockets of discrimination against the osteopathic community, and osteopathic physicians must continue to fight for equal treatment.

Significantly, while DOs constitute only 5.5 percent of the nation's physician manpower, they are often the only physicians practicing in many rural and underserved communities. Osteopathic physicians comprise more than 15 percent of all physicians practicing in communities of less than 10,000 people and fully 18 percent of physicians serving communities of 2,500 or less. Additionally, DOs comprise ten percent of all physicians serving in the uniformed services. In all, whether serving in rural or urban areas and in public service or private practice, the nation's osteopathic physicians provide care in nearly one hundred million patient visits each year.

Osteopathic medicine has recently received attention for its production of an appropriate balance of primary care physicians and specialists. More than 60 percent of the profession consists of primary care physicians who provide a complete range of services to patients of all ages. This statistic is no fluke. Throughout its history, the osteopathic profession has consistently been able to exceed the proposed federal recommendations for 50 percent of the nation's physician workforce to be comprised of primary care physicians. Each year, more than half of the osteopathic medical school graduates choose to enter practice in primary care fields. A recent study to determine which medical schools -- allopathic and osteopathic -- produce the largest percentage of primary care physicians revealed that 15 of the top 25 and all of the top ten were colleges of osteopathic medicine.[3] The success of the osteopathic profession in

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[1]For example, Medicare defines physicians as including osteopathic physicians (42 U.S.C § 1395x(r)); Hospital accreditation by the AOA is statutorily recognized (42 U.S.C. § 1395bb(a); and osteopathic physicians are statutorily authorized to practice medicine in the Public Health Service (42 U.S.C. § 209(d)), Medical Corps (10 U.S.C. § 532(b)), Veterans Administration hospitals (31 U.S.C. § 4105(a)(1)), and Federal Health Service (5 U.S.C. § 7901(e)).

[2]See Stern v. Tarrant County Hospital, 778 F.2d 1052, 1060 (5th Cir. 1985), cert. denied, 476 U.S. 1108 (1986) (noting that osteopathic physicians and allopathic physicians have similar training and face identical testing and licensing requirements); Brandwein v. California Board of Osteopathic Examiners, 708 F.2d 1466, 1468 (9th Cir. 1993) ("At the present time the differences between the schools of osteopathy and allopathy are minor"); Weiss v. York Hospital, 745 F.2d 786, 792, 820-22 (3d Cir. 1984), cert. denied, 470 U.S. 1060 (1985) (noting at footnote 4 that an MD had testified as to the fact that there was no difference between graduates of allopathic and osteopathic medical schools in terms of medical training and ability to provide medical care, and, at page 820 that the defendant hospitals did not contend that osteopathic physicians are less qualified, nor did the hospitals offer any "public service or ethical norm rationale for their discriminatory treatment of DOs.").

[3]L. Haspel, DO, Osteopathic Graduate Medical Education: Past, Present & Future (1995) (study completed for the Josiah Macy, Jr. Foundation).

producing community-level primary care medical practices is the result of the profession's carefully crafted educational program that emphasizes primary care and the osteopathic philosophy at all levels of education and training.

Osteopathic physicians start their medical careers by earning the degree of Doctor of Osteopathy or Doctor of Osteopathic Medicine (DO). Presently, there are 16 accredited colleges of osteopathic medicine located in 14 states.* The colleges enroll qualified applicants who have completed four-year college degrees and often advanced graduate degrees. Requirements for graduation from osteopathic medical colleges include the successful completion of a four-year curriculum of basic sciences and clinical studies, including the same subject matter taught in allopathic medical schools.

While the education of an osteopathic physician includes the same materials required of allopathic physicians, the education also emphasizes principles of osteopathic care. As the osteopathic philosophy places an emphasis on the musculoskeletal system and holistic care, so too does the curriculum in our medical schools. In addition, osteopathic medical students receive training in the administration of manipulative medicine. In the first two years, the standard osteopathic curriculum includes two to three hundred hours

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*Chicago College of Osteopathic Medicine, Midwestern University - Chicago, Illinois

College of Osteopathic Medicine of the Pacific - Pomona, California

Kirksville College of Osteopathic Medicine - Kirksville, Missouri

Lake Erie College of Osteopathic Medicine - Erie, Pennsylvania

Michigan State University, College of Osteopathic Medicine - Lansing, Michigan

New York College of Osteopathic Medicine, New York Institute of Technology - Old Westbury, New York

Nova Southeastern University, Health Professions Division, College of Osteopathic Medicine - North Miami Beach, Florida

Ohio University College of Osteopathic Medicine - Athens, Ohio

Oklahoma State University College of Osteopathic Medicine - Tulsa, Oklahoma

Philadelphia College of Osteopathic Medicine - Philadelphia, Pennsylvania

University of Health Sciences, College of Osteopathic Medicine - Kansas City, Missouri

University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine - Stratford, New Jersey

University of New England, College of Osteopathic Medicine - Biddeford, Maine

University of North Texas Health Sciences Center at Fort Worth, Texas College of Osteopathic Medicine - Fort Worth, Texas

University of Osteopathic Medicine and Health Sciences, College of Osteopathic Medicine and Surgery - Des Moines, Iowa

West Virginia School of Osteopathic Medicine - Lewisburg, West Virginia

which focus on manual medicine, and the concepts that the body's systems are interrelated, that a dysfunction in one system may be reflected in a dysfunction in another, and that the body has a self-healing capacity.[3] Osteopathic medical schools expose their students to clinical experience at an early stage in their training, typically including a 14-week family medicine clerkship in addition to another 16 weeks in pediatrics and internal medicine.[4] This curriculum is part of a larger process of teaching all students to be primary care physicians first and foremost.

Following graduation, osteopathic physicians generally embark on a course of unique graduate medical education. Just as osteopathic medical education differs from allopathic education, so too do the postdoctoral training programs. The graduate medical educational program is designed to build upon the osteopathic concepts taught during medical school. The internship year of osteopathic graduate medical education required for entry into osteopathic residency training, includes mandatory rotations in primary care areas of internal medicine, obstetrics and gynecology, general pediatrics, family practice and surgery. In addition, the required curriculum for internships states that "Osteopathic principles and practices shall be incorporated throughout the program."[5] Following internships, the physicians progress to residencies in primary care and other specialties. The osteopathic internship with its rotations in areas of primary care is required regardless of whether a physician contemplates a non-primary care specialty, such as anesthesiology or radiology. It is our understanding that such required primary care content is not included in allopathic non-primary programs. Moreover, all of our residency training programs, as with our internships, incorporate osteopathic concepts. The AOA residency training curriculum requirements include "Utilization of osteopathic principles and practices relating to the specialty."[6] The osteopathic system of graduate medical education creates a profession in which all facets of primary care and specialty care are represented. The osteopathic profession has become one in which primary and non-primary specialties are balanced in a way that more properly reflects the needs of our society.

With this explanation of osteopathic medical care and osteopathic medical education in mind, I would now like to address directly the issues of Graduate Medical Education and the AOA's recommendations for this Committee.

1. Allocation of Positions

The program of osteopathic predoctoral and postdoctoral medical education and training produces high quality physicians who practice in primary and specialty care fields. Our program of graduate medical education reflects our belief

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[3] C. D. Meyer, DO, Osteopathic Medicine: Past, Present and Future: What's Distinctive About Osteopathic Medicine (March 1995) (presentation for the Josiah Macy, Jr. Foundation).

[4] Id.

[5] Policies and Procedures for Intern Training, Section VII, D, 1 (American Osteopathic Association, March 1993)

[6] Residency Training Requirements of the American Osteopathic Association, Section II, C, 3, e (American Osteopathic Association, July 1992).

that all properly trained physicians should have knowledge of primary care and specialty care areas in order to be able to provide complete medical care. This unique program has achieved an appropriate balance of primary care physicians and specialists. Among osteopathic physicians currently in practice, more than sixty percent are primary care physicians.

While osteopathic physicians have developed and refined this educational model over the course of time, the federal government plays an essential part in its continued success through funding of graduate medical education. A variety of legislative proposals have attempted to address the significant questions of how many and what type of physicians will be needed in the future.[1] Questions of how best to fund Graduate Medical Education must be considered as part of this process. At present, federal funding is intended to foster development of an appropriate number of physicians in different practice areas.

The AOA supports the government's efforts to encourage more physicians to practice in primary care fields. As policy is developed, we must hope that osteopathic programs receive an appropriate portion of available funds. Without continued support for osteopathic training programs, our graduates will lose the benefit of an osteopathic graduate medical education that has been proven to be very valuable in meeting health manpower needs. For osteopathic practice to survive, the profession must be able to maintain its distinct educational program beyond the medical school level. The simple fact is that osteopathic education requires more than the medical school experience; complete training in the osteopathic approach to medical care requires continued application of osteopathic principles and procedures in osteopathic postdoctoral training programs.

The question of how many graduate medical education positions should be funded is one issue which this committee may consider. Many organizations and individuals have recommended that the total number of funded residency positions be limited to the aggregate number of osteopathic and allopathic medical school graduates. While the AOA generally concurs with this position, we believe that the number of funded GME programs should be designated separately and proportionately for osteopathic and allopathic programs.

DOs comprise a small, but distinct minority of physicians. If funds for allopathic and osteopathic graduate medical education are intermingled, there is some danger that, through either deliberate or inadvertent actions, osteopathic programs would not receive sufficient graduate medical education funds. This would be particularly the case if the osteopathic allocation was buried within a single allopathically dominated allocation formula. However, if the funding is separately earmarked for osteopathic and allopathic use, then there is assurance that the necessary funds will be available for osteopathic programs, which already comply with the federal mandate for primary care.

With a secure and separate source of funds, osteopathic physicians will be able to maintain a complete osteopathic medical education system, which produces an appropriate primary care/specialty balance and physicians who bring primary care to areas which sorely need such care. Of

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[1] See, e.g., the proposals contained in the proposed Health Security Act, H.R. 3600, 103d Cong., 1st Sess. §§ 3001 et. seq. (1993).

course, in order to guarantee sufficient funds, the allocation must be in appropriate proportion to the number of osteopathic medical graduates. We suggest that in a separate allocation system, the number of funded allopathic residency programs would be determined based on the number of graduates of allopathic medical schools, while the number of funded osteopathic postgraduate programs (internships and residencies) would be determined based on the number of graduates from osteopathic medical schools.

The AOA proposed the idea of a separate and proportionate allocation of funds for osteopathic GME to Congress and the Council on Graduate Medical Education ("COGME"). In response, COGME concurred with the AOA's suggestion and recommended that funding for postgraduate training programs be allocated on a separate basis for allopathic and osteopathic physicians.[10] While osteopathic and allopathic educational programs both produce complete practicing physicians, their respective educational models -- from medical school through graduate medical education -- are different. By guaranteeing a separate funding allocation for osteopathic postdoctoral training programs, Congress will help to ensure the continued vitality and viability of osteopathic medical care.

2. Funding for Graduate Medical Education.

I would next like to discuss the criteria for funding respective Graduate Medical Education ("GME") programs and the source of such funds. Currently, there are separate formulas for reimbursement of direct and indirect GME costs incurred by teaching hospitals.

Direct GME costs are reimbursed under a formula which is based on each hospital's 1984 costs per resident, adjusted for inflation.[11] Since 1984 there have been significant changes in graduate medical training, particularly within the osteopathic profession. Non-salaried volunteer faculty has given way in large measure to salaried faculty. Osteopathic programs have grown relative to their allopathic counterparts and have consequently incurred additional costs for additional faculty, such as program directors and clinical supervisors. These costs were already imbedded in the large allopathic programs in 1984 and, therefore, included with their base year measure. Because most of our faculty salary expenses have arisen since 1984, osteopathic programs have lost ground relative to the allopathic programs, despite cost of living adjustments. COGME is aware of the fact that a similar situation exists in the allopathic profession with respect to the large academic health centers versus smaller teaching institutions. Consequently, both COGME and the osteopathic profession are urging that at the very least, the base year for measuring direct costs be changed from 1984 to as current a year as possible in order to take into effect actual changes and thereby create a more level playing field.

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[10]Council on Graduate Medical Education, Recommendations to Improve Access to Health Care Through Physician Workforce Reform, Fourth Report to Congress and Department of Health and Human Services Secretary (1994).

[11]Direct Graduate Medical Education (DGME) payments to each hospital equal the hospital's updated base-year (1984) costs per FTE resident, times the weighted average number of FTE resident, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. GAO/HEHS-94-33 Medicare GME Payment Policy.

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COGME has also recognized that the current reimbursement formula for direct costs is skewed heavily in favor of the large academic health centers for a number of reasons, including the ability of the larger institutions to involve a proportionately greater number of staff members in the compensated teaching faculty. COGME, therefore, is advocating that the current formula, which is based on each institution's actual 1984 costs, be replaced by a formula based on a national per resident average cost (possibly with regional adjustments). We join COGME in urging this change. The updating of the base year and the change to a national average will create a fairer and more rational system of determining each institution's level of reimbursement for direct costs of GME programs.

The adjustment in the funding of graduate medical education should not be limited to the means of direct funding. We also believe that the system for reimbursement of indirect costs of GME should be reformed.[12] The present formula is based in significant part upon the training program's resident-to-hospital bed ratio. Again, larger academic health centers have the resources to maintain such ratios at a significantly higher level than their smaller counterparts. Again, we and COGME urge that this method of measuring indirect costs of GME be replaced by a formula employing an updated historic base year experience figure.

Third, the source of funds for reimbursing the direct costs of GME should be addressed. Presently, such funds are provided in large part by Medicare/Medicaid and Blue Cross/Blue Shield. We agree with COGME's Fourth Report that "the direct costs of GME be funded by all third-party payers through the development of a national GME funding pool."[13] With the growth of managed care, it is essential that managed care groups and all insurers in the private sector pay their fair share of GME direct costs.

One last topic with respect to funding involves the fact that osteopathic teaching hospitals are typically smaller, community-oriented facilities. Because of the current funding system's rewards for larger institutions, the osteopathic hospitals have not had the benefit of elaborate resources for payment of faculty and trainees. Yet, osteopathic medicine is developing alternatives. Consortia of hospitals and colleges of osteopathic medicine have emerged in various locations to expand and enhance graduate medical education for training in family medicine, internal medicine and other specialties within the profession.[14]

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[12]Medicare Indirect Medical Education ("IME") payments to each hospital are based on a formula that provides an increase of approximately 7.7 percent in the federal portion of the DRG payment, for each 0.1 increase in the hospital's intern and resident to bed ratio. GAO/HEHS-94-33 Medicare GME Payment Policy.

[13]Council on Graduate Medical Education, Recommendations to Improve Access to Health Care Through Physician Workforce Reform, Fourth Report to Congress and Department of Health and Human Services Secretary (1994).

[14]For example, the COGMET program established by Michigan hospitals and the College of Osteopathic Medicine at Michigan State University in Lansing, Michigan and the Family Practice program established by Ohio hospitals and the College of Osteopathic Medicine at Ohio University in Athens, Ohio have had particular success in developing graduate medical education programs in primary care.

The trend in many cases is for the consortia to make increasing use of ambulatory care settings for teaching purposes. We believe that the funding programs should recognize these consortia on an equal basis and fund them accordingly. With proper funding, these consortia will prove to be extraordinary programs for the training of another generation of osteopathic physicians to provide high quality medical care.

3. Enrollments

The last issue of Graduate Medical Education that I would like to address is the subject of recommended enrollments in medical school. The AOA has advocated that osteopathic graduate medical education programs be funded on a separate but proportional basis with respect to allopathic programs. Certain organizations and individuals have gone on to recommend that the total number of funded residency positions be limited to the aggregate number of osteopathic and allopathic medical school graduates.

As I indicated earlier in my testimony, the AOA generally concurs with this position, but notes one particular reservation. While some parties have urged that the number of residencies should be tied to the aggregate number of students in a particular "base year," we believe that the base year concept is not appropriate insofar as it fails to recognize that the osteopathic profession continues to grow and develop. While the number of residency positions should be tied to the number of graduates, such measure should contain a reasonable provision for growth in such numbers.

Over the past several years, the number of physicians graduating from colleges of osteopathic medicine has regularly increased,[1] in part as a result of federal plans developed in the past to expand primary care capacity in the United States. Use of a base year would not account for enrollment growth in osteopathic medical schools and could deprive the osteopathic profession of funds needed for the education and training of our graduates. With the base year cap, graduate medical education programs would not have the funding to allow for program expansion as the number of graduates of osteopathic medical schools grows. In effect, the use of a base year would punish the profession that is currently producing a proper balance of specialists and primary care physicians, which balance is deemed critical for reform of the health care system.

Some additional clarification is necessary with respect to the growth of osteopathic medical schools. First, we believe that the continuing growth of enrollment in osteopathic medical schools serves the nation's needs. Osteopathic physicians, with their balance of specialists and primary care and practice in underserved communities, are the type of physicians needed in this country. A fair division of federal funds which allocates separate and appropriate amounts to osteopathic graduate medical education will enhance our ability to expand and improve the postdoctoral training component of our educational system.

Finally, it should be noted that the significant growth in numbers of residents is not due to growth in enrollment in U.S. medical schools so much as to the increasing presence of

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[1]Between 1980 and 1995, the number of osteopathic physicians per 100,000 people in the United States increased from 8 to 14.

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international medical school graduates in American residency training programs."

Conclusions

Osteopathic medicine provides a vital component of the nation's health care services. As policy makers attempt to encourage more physicians to enter primary care fields of practice and provide services to underserved areas of the nation, we point with pride to our history of serving both these needs.

The osteopathic orientation towards primary care practices supported by a cadre of well-trained specialists and history of providing care in underserved communities are not the result of a statistical aberration. Rather, these goals are fostered through a complete osteopathic educational program. An essential component of osteopathic education is graduate medical education. The present system of funding educational programs has resulted in an inequitable distribution of resources. Osteopathic hospitals are typically smaller, community-based treatment centers. When resources are distributed in accordance with the assumptions present in an outdated base year and without considering factors such as participation in consortia of educational institutions, the osteopathic training sites are not provided with an equitable share of the resources. Without sufficient funding, osteopathic hospitals are not able to improve their educational facilities and expand the number of full time faculty. If the base line measure is replaced with a national average system of funding and consortia are given full consideration, then osteopathic programs will be put onto a level playing field with allopathic graduate medical education programs.

We believe that growth in osteopathic physicians will help to solve current shortages of primary care physicians, maintain an appropriate primary care-specialty distribution and provide physicians for traditionally underserved communities. In order to assist the country in meeting these challenges, we would suggest that Congress and this committee act to correct the current imbalances in funding for graduate medical education. Specifically, we would suggest that osteopathic graduate medical education programs receive a separate and proportionate allocation of the funds devoted to postdoctoral education. Funding criteria should be modified in order to consider the participation of programs in consortia of educational programs rather than looking purely at hospital size. Finally, we recommend that funding allocations be made without reference to any base year in order to allow for funding to change with the population such funding serves. With proper support for osteopathic graduate medical education, osteopathic physicians will be able to continue our history of providing high quality, primary and specialty care medical services.

"Between the 1990-91 and 1993-94 academic years, the total number of residents training increased by 12,737 (from 95,327 to 108,064). However, during the same period of time, the number of United States Medical Graduates training in United States GME programs only increased by 4,996 (from 79,311 to 84,307). Thus, in four years, the percentage of International Medical Graduates training in United States GME programs jumped from 16.8 percent to 21.98 percent. L. Haspel, DO, Osteopathic Graduate Medical Education: Past, Present & Future (1995).

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Dr. Anderson.

I regret that I was not able to be here for the whole panel. I had an amendment on the floor. Those things end up taking a lot longer than you anticipate.

But I appreciate your testimony, Dr. Anderson. I had not really factored in osteopathic issues, and I do not know whether, when we talk about the number of residencies in America, are we talking about and do we include the osteopathic residencies as well?

Dr. ANDERSON. When I speak of funding 110 percent of the graduates, both osteopathic and allopathic medical schools—and I am saying right now we are talking about a total of about 19,000 physicians that will graduate every year ——

Mrs. JOHNSON OF CONNECTICUT. Does the osteopathic system have its own separate residency program?

Dr. ANDERSON. Yes, it does. Now there are some osteopathic physicians that are in allopathic programs.

Mrs. JOHNSON OF CONNECTICUT. Right.

Dr. ANDERSON. But there is an osteopathic system of training residents, yes.

Mrs. JOHNSON OF CONNECTICUT. So you are saying if we look at caps, it should be across both systems. If we look at residency positions, we should look at residency across both systems.

Dr. ANDERSON. That is correct. It should be proportional in the allocation, recognizing the two separate systems.

Mrs. JOHNSON OF CONNECTICUT. Can you accurately factor out how much of a resident's time is devoted to training and how much is devoted to service? This is to the whole panel.

Dr. ANDERSON. That is very difficult. I would say--and I am a medical educator—it would be very difficult to separate that out.

I could tell you this. The residents themselves would be very eager to tell you how much of it is, "scut work" versus education. But from an educator's perspective it is difficult to separate these two out.

Mrs. JOHNSON OF CONNECTICUT. Also since much of life is scut work, it is hard to determine which is training.

Dr. Jacott.

Dr. JACOTT. I would just like to build on that a little bit. That is a question that has been asked for many, many years, and we have tried to look at it from every angle, and you add a third component, not just service and education, but then you add research as the third piece of the academic mission and try to figure out how they sort out timewise. It is very difficult. I have not seen any studies that clearly split out that time ratio.

Mrs. JOHNSON OF CONNECTICUT. What we are really trying to do in government is exactly what the private sector has tried to do. What exactly are your cost centers, and how does the money flow? How much is research? How much is training? How much is service? And what is the Medicare premium? How much of the Medicare premium is care for seniors for the patient, and how much is subsidy to training, and how much is subsidy to uncompensated care, and how much is subsidy to the institution, so that they can carry on their academic mission?

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This is something that we have never been very good about doing, but it is something that we are going to have to do, because I am sure it was said by others as well, but Dr. Anderson mentioned it most recently. We are going to have to make change, and we are going to have to do that through providing seniors with a lot more options, and to provide them with options, you have to know what the premium is.

So any help you could give us as we try to disentangle the dollars and the missions would be appreciated.

Mr. Munson.

Mr. MUNSON. Thank you for the question. I am also sorry you missed my spellbinding testimony, but that is all right.

To the contrary, I do not believe that government and Medicare are doing just like the private sector. I think you have done a very nice job historically in differentiating the elements of cost that you choose to pay for.

There are five of them: The PPS payment or the DRG payment for the actual service rendered; the IME payment to hospitals like mine, which recognizes the unique severity and comorbidity that the patients bring to our place; the DGME payment, which is a direct cost of house staff stipends and related costs; disproportionate share for those of us that take shares of poor folks; and then outliers for patients, for example, those in our burn unit that stay for 200 days with huge burns.

So on the contrary, I do not think you are doing what the private sector is doing at all. I think you are doing a nice job of identifying, accounting for, and then paying segmented parts of the cost of rendering care to seniors.

On the contrary, as I said in my testimony, the private commercial sector is trying to avoid almost all of that societal responsibility.

Mrs. JOHNSON OF CONNECTICUT. Let my chairman jump in here.

Chairman THOMAS [presiding]. A brief response to that.

Obviously the payment system grew up in part in response to need and part in response to politics. And you are right; the profile fits.

A vision of a teaching hospital, perhaps less so today than earlier, more so earlier than today—and as you are moving out into the community and clinics and stressing—and I came in on the discussion between service and training, and my background is as an educator as well, and you cannot let the students determine when it is happening, because sometimes in a context that you consider to be very educational and useful, they consider it to be drudgery.

And, in fact, we heard earlier testimony, and I believe it to be true, that a lot of the training that is necessary is interpersonal relations, dealing with folks who maybe are not necessarily doctors, and you need to do that, and that is kind of like a work training program, which is almost seamless. You cannot separate it.

But our problem is that I do not want to dictate how much the percentage should be or even get the educational training process into a 60:40, 70:30 game in terms of how we fund it.

Nor do I think that we can continue the current structure based primarily on hospitals running money to those folks on the patient profile through the indirect, which really is, I think, as you more

accurately described it, is a reward for the profile of the patient more than, you know, just the teaching structure.

Then with the disproportionate share, it just makes sense because of the urban locations. As I said in my opening statement, that is where most of them are.

But the hospitals are relatively less significant in the new structure, and perhaps the profile of the patients and what is being done is becoming less significant, so we have got to make it more relevant, and we move that structure, and if that is the case, then the old-fashioned funding mechanism needs to change as well.

To the degree that things remain the same, the funding system makes sense. I think our problem is that they are not remaining the same, and we have got to figure out a way to begin to shift that funding structure that does not produce the Federal Government quotas and divisions in the teaching areas and, in fact, rewarding some beyond what they should have been rewarded and not rewarding others sufficiently because of the location if we change the funding structure.

So I think we are sensitive to the problem. It is just that it is going to be an enormously difficult political problem, which is not partisan, by the way. You heard the gentleman from California. It is not partisan. It gets into some regional aspects—States, teaching hospitals in their States, and the profiles that those hospitals have developed, and that if you change the formula, you change the winners and the losers.

And so all of that will be entering into our decision, notwithstanding the fact that the fundamental basis for funding medical education is eroding because hospitals themselves are becoming less the focal point.

You folks are essential to our coming up with a program that actually is better and actually does solve the problem and does not exacerbate problems that we either know or do not know about.

So I apologize for not hearing your scintillating testimony either, but you need to know that we read all this stuff as well, and I thank you.

Mrs. JOHNSON OF CONNECTICUT. Mr. Munson, I know that we are only giving a minute-and-a-half summary of something that is much more important than that. But your summary does worry me.

Now your comment that the private sector is not taking its societal responsibility, it is true that their premiums are focused primarily on the health costs of the patient they have insured. And then, through taxes, they would maintain that they are taking their societal responsibilities, send the government the money that the government needs to do whatever government thinks is important.

Now it may be that they ought to be paying a premium tax directly, so that we can fund medical education, and that is not a concept that I think is beyond grasp or adoption.

But to then say that the government is doing a better job does worry me terribly, because the disproportionate share thing, we guess at that.

Outliers? Finally after you bent our arms, we did acknowledge that if someone is in the hospital way beyond what the DRG ex-

pected, you might need additional reimbursement. There is still a lot of question about whether it is fair to have the outlier kick in at day 90 or day 80, but the outlier controversy is real.

DRGs? You can hardly believe what my constituents think about DRGs when they get it. When they come into my office with a Medicare bill that shows that their costs—and I am making up the figures—were $1,000, and the hospital got paid $2,500, and they have to pay 20 percent of the $2,500 or fix the numbers so that the 20 percent comes out bigger than the actual payment, this does not strike them as rational, as fair, or as real.

So while the DRG system was a sort of desperate response to desperate circumstances on the part of the government, and the concept of reimbursing on average did help us through a crisis, this is not a model that interests me for the future.

I think for the future we have to get much tougher in the public sector. We have to figure out what care is being given and how it is being given, or we have to move public recipients of every type into the choices the private sector offers. If we do the latter, then we have to think about how do we cover those who do not have any insurance? How do we pay for medical education?

But it is that latter debate that really interests me a lot more. The current reimbursement structure I consider to be of the same ilk of public policymaking that decided that under Superfund we were going to charge people to clean up things that they did that were completely legal at the time they did them, regardless of whether or not they have the money to clean it up now or regardless of whether or not we are going to take all their pension savings, their home, their mortgage, their everything else.

I mean, I do not see the public reimbursement fund structure as any model on which to base the future. So it troubles me that you would make the comment that the private sector is offbase and the public sector is onbase, when I think the reverse is actually my reality.

Mr. MUNSON. OK. You have said a lot, and you have left a lot to respond to.

I did not mean to suggest that the Medicare reimbursement system is perfect or that all the regulations and formulae are perfect.

On the contrary, what I did mean to imply is that the various elements of reimbursement contemplate important societal contributions that teaching hospitals make—education, care for the severely ill and injured, and then the disproportionate share program for poor people.

Mrs. JOHNSON OF CONNECTICUT. Right.

Mr. MUNSON. So all I was saying is that the program, in its entirety, contemplates some things that are very important to society and to teaching hospitals.

I do not believe that the commercial managed care HMO products, albeit, yes, they do pay taxes, but that does not help offset their portion of direct medical education which occurs in our places.

During my remarks, I mentioned the paradox of these same companies who want to hire one of our products, namely primary care doctors. We produce a lot of those. They want to buy them, but they do not want to pay the cost of production. Medicare histori-

cally has wanted to pay the cost of production. That is the kind of difference I was alluding to.

Mrs. JOHNSON OF CONNECTICUT. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Just to follow that up, we heard testimony earlier that, in fact, the product—it sounds like most of the products coming out of most schools—the product of primary care physicians are, in fact, not equipped to deal with the new world of medicine under managed care. It seems to me that if they are getting a product which they cannot use immediately, schools should plug them in in an efficient way and have them deal with additional training or working on their interpersonal skills with health professionals who are not doctors. They might be interested in contributing a portion of the education cost to get a product that they can use immediately and who has been trained along the lines that they believe to be appropriate.

So I guess as we pursue this, I think you are going to find that the marketplace in terms of what it asks for, to the degree it asks for a product different than is being produced today, is going to be asked to pay for the changes in that product.

And we have begun discussions, and we will continue discussions in terms of a fair share pay.

The easiest way, obviously, is to get a different funding system that is broader based. But we discussed that. It is very difficult to do politically, and it is very difficult to create a different system because of the way in which this one fits circumstances that have not completely changed but are changing.

So we are going to try to do two things, keep the best of what we have had and anticipate how we can get those folks who may not be paying their fair share or who are complaining about the product coming out of the structure, to say: OK, you know, put your money where your mouth is, and let us talk about bringing about changes.

It will be not as perfect as we would like, but there are going to be changes made. And I believe you will find that it will be a broader-based support for the costs with an expectation that the product coming out of it will be more relevant to the needs of the marketplace.

Dr. Jacott.

Dr. JACOTT. I am really delighted, Mr. Chairman, to hear you saying that, because we do—those of us in academic health centers and in education programs—and my background is family practice—and we do hear a lot from the managed care entities that we are not training the kind of person that they want to come out into practice.

On the other hand, we need to look at what their expectations are. If we are just training a triage officer or a gatekeeper, that is really not satisfactory either, to provide the kind of care.

On the other hand, many of our educational institutions have developed within their training programs the kind of information and experience that the residents need to get out and practice in a managed care environment.

At the University of Minnesota, in our Department of Family Practice, we have our own HMO, and it is basically run by the resi-

dents, and the residents have come out and they are marvelous in managed care, if that is what the managed care people are looking for.

But I cannot agree with you more that if they want to say something about the product, then they ought to be paying for the product.

Chairman THOMAS. Well, but beyond that, I think we need to focus on medical training and education in terms of producing the complete product for the marketplace. And we are going to have a panel following you folk, who will be focusing on other aspects of health care professionals. And clearly as managed care utilizes more and more other health professionals who are not doctors, there needs to be a coordination between them.

It makes sense to do more of that during the education and training process rather than on the job. So I think if we are realistic, the profile of who is going to be trained in these centers is going to change as well.

And to the degree that we have too many doctors not of the right type and that we need more folks who are not doctors, you can be doing the right thing with a shrinking universe, or you can be doing the right thing with a larger universe of all of the kinds of people that we prepare and work with.

That is another thing I think we need to try to do, and that is direct the funding, one, to the environment in which it needs to go and, two, to the broader population universe which will be necessary in the future.

That is all uncomfortable for everybody, because it is a significant change, foremost in terms of the impact of the changes on the doctors themselves.

So this is a challenge for all of us. But to the degree that the Federal Government is going to fund medical education for the rationale being a societal good, then we are going to make sure that the product is not misplaced in terms of its emphasis and its need in the marketplace.

It is changing. And we appreciate your testimony. And we are going to move in the direction of trying to provide more realistic funding in realistic ways that allow you to produce realistic folk to serve in the realistic structure of tomorrow.

Dr. ANDERSON. Could I make just a comment?

Chairman THOMAS. Certainly, doctor.

Dr. ANDERSON. I would certainly hope that the managed care organizations would take note of what you have said relative to the responsibilities that they should assume. As long as they have the strong bottom line orientation that they have, and there is no demand placed on them—that is, there is a sufficient pool out there that they can weed out the doctors that do not have that training in managed care—I would like to see a requirement made of those who benefit to participate in graduate medical education. That certainly would include the HMOs.

Chairman THOMAS. If they are not listening, we will deliver the message anyway.

Dr. ANDERSON. Thank you. I hope you do that.

Second, I think to attempt to dissect out now what portion of a resident's time is spent in training, we know the elements that go

into making up the total amount of the payments; I think we should look more at the finished product.

Are we producing—and you made that observation, Mr. Thomas—we should look at the product to determine whether or not we are producing the kind of physician that we need to meet societal needs.

If we are not doing that, without regard to how much it costs, we should stop. We should stop.

So when I say look at 110 percent funding, 110 percent of the positions for our graduates, if that meets the needs, that is where the funding needs to stop.

Chairman THOMAS. Yes. And a lot of times it is not what, it is where. And more and more it is where they are getting it. And I would much rather emphasize an open structure, so that you folks can get them trained where they need to be trained in terms of reflecting what tomorrow looks like, rather than getting into percentages that may or may not be education versus training.

I thank the panel very much.

Dr. ANDERSON. Thank you.

[Pause.]

Chairman THOMAS. The last panel can now take their place, and we have got: Gwendylon Johnson, Kenneth Kalkwarf, and Charles Jones.

As I indicated to the other panels, your written testimony will be made a part of the record without objection, and you may proceed to educate and inform us as you see fit in the time that you have.

Ms. Johnson, if you will start, then we will move across to Mr. Kalkwarf and then on to Mr. Jones, if you will begin.

STATEMENT OF GWENDYLON E. JOHNSON, M.A., R.N., C., MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES ASSOCIATION

Ms. JOHNSON. Thank you, Mr. Chairman, and members of the subcommittee.

I am Gwendylon Johnson. I am a member of the board of directors of the American Nurses Association. Thank you for the opportunity to discuss graduate nurse education.

The American Nurses Association is the only full service professional organization representing the Nation's 2.2 million registered nurses.

We are also testifying today on behalf of the American College of Nurse Practitioners, the Association of Operating Room Nurses, the Emergency Nurses Association, and the National Association of Nurse Practitioners in Reproductive Health.

America's registered nurses deliver many essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings.

Because we are there 24 hours a day, 7 days a week, we know all too well how the system succeeds so masterfully for some, yet continues to fail so shamefully for all too many others.

Nursing commends Congress for its increased focus on nurse education issues. It is clear that the U.S. health care system has an increasingly urgent need for primary care providers.

Funding must be made available to strengthen advanced practice nurse programs and to establish new programs to prepare those primary care providers so urgently needed.

Nurses are well positioned to fill many of the gaps in the availability of primary health care services. Advanced practice nurses are trained to provide from 80 to 90 percent of the necessary primary care services of the Nation. Advanced practice nurse education includes the preparation of nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified nurse anesthetists. These advanced practice nurses are prepared as expert clinicians to deliver primary care and other services vital to the Nation's health care needs.

Since its inception, the Medicare program has paid a portion of the cost of training health professionals. Graduate medical education expenditures for nursing education are intended to reimburse a portion of the cost of nurse education to promote quality inpatient care for Medicare beneficiaries.

Thus, Medicare has traditionally made payments to hospitals for the training of nurses in hospital-based nurse education programs. A majority of these programs are hospital-based programs that grant a diploma, rather than a bachelor of science degree that is granted by most university-based nursing education programs, or an associate degree granted by community colleges.

As the need increases for community-based and primary care providers, nursing will be forced to expand the number and capacity of its graduate level education programs. These programs do not currently receive Medicare funding.

In order to quickly expand the number of these expert clinicians, there must be an increased Federal commitment to graduate nurse education, a commitment not subject to the uncertainties of the annual appropriations process.

We urge this committee to redirect a portion of the annual Medicare funds currently being used to reimburse diploma nursing education over a 3-year phase-in period to graduate nurse education programs.

However, since there is also a continuing need for 4-year BSN-prepared nurses to play a variety of critical roles in the evolving health care system, we believe that the current Medicare funds reimbursing hospitals for those programs must be maintained.

We also believe that funding must be available to the 72 existing programs offering what is termed an "RN to MSN" program. In essence, these are accelerated nursing education programs that enable diploma and associate degree nurses to become master's prepared and hence, better able to meet the primary health care needs of the Nation. These programs allow for a readily available pool of skilled health care professionals to become educated as advanced practice nurses in a short period of time.

A graduate nurse education program would help many graduate nursing students who are currently attending school part time due to financial constraints to become full-time students.

The current cost of obtaining a nurse practitioner education is similar to students pursuing master's degrees in other subjects. A division of nursing study estimated that the average cost is about $34,000 per graduate. A large portion of graduate nursing student programs are in clinical practice. Some certifying exams require that the nurse spend one-third of his or her education in the classroom and two-thirds in clinical practice.

Advanced practice nurses currently train in a variety of settings—hospitals, skilled nursing facilities, home health agencies, nurse managed care centers, ambulatory care facilities, HMOs, public health departments, and community health centers.

Therefore, even as advanced practice nurses are training for their degrees, their services are being utilized in providing much needed health care services to patients. However, nursing programs and students currently incur the cost of the support of the clinical training in the advanced practice nurse education, despite the fact that these students are providing direct health care similar to many medical residents.

Funds should be available to nurses to help them defray tuition and fees and provide student stipends, as well as reimburse the costs for faculty supervision at the clinical site.

Mr. Chairman, we commend you and the other members of the subcommittee for holding this hearing on graduate medical and nurse education and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as you develop solutions to this critical problem.

Again, thank you very much.

[The prepared statement follows:]

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TESTIMONY OF GWENDYLON E. JOHNSON
AMERICAN NURSES ASSOCIATION

Good morning, Mr. Chairman and Members of the Subcommittee. I am Gwendylon Johnson, RN, a member of the Board of Directors of the American Nurses Association.I am here today on behalf of the American Nurses Association (ANA), the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives, nurse educators, nurse managers and certified registered nurse anesthetists through its 53 state and territorial nurse associations.

I am also testifying today on behalf of the: American College of Nurse Practitioners, a group of nurse practitioner organizations who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care; Association of Operating Room Nurses, Inc., the professional association of perioperative nurses representing 47,600 members who are all registered nurses specializing in care of the patient undergoing surgical and other invasive procedures; Emergency Nurses Association, a voluntary membership association of nearly 21,000 professional nurses committed to the advancement of emergency nurse practice; and the National Association of Nurse Practitioners in Reproductive Health, a national non-profit membership association representing nurse practitioners who practice in obstetrics, gynecology, family planning, reproductive endocrinology and infertility whose purpose is to assure the availability of quality reproductive health services.

We appreciate the opportunity to testify on graduate nurse education. We have long advocated for high quality, affordable health care for everyone in this nation. America's registered nurses deliver many of these essential health care services in the United States in a variety of settings -- hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice, and in managed care settings. As the health care delivery system continues to evolve rapidly in the coming years, it is crucial that all available health care professionals be fully prepared to deliver essential primary care services. To meet the increasing demands on our health care system, funding must be guaranteed to strengthen existing advanced practice nurse education programs and to establish new programs to ensure an adequate supply of these primary care providers.

BACKGROUND

Nurses are well-positioned to fill many of the current gaps in availability of and access to primary and preventive health care services. Advanced practice nurses are registered nurses who are nurse practitioners, clinical nurse specialists, nurse mid-wives or nurse anesthetists who have obtained specialized formal education and training beyond the education that prepared them to initially become a registered nurses (beyond the four year Bachelor of Science degree). In most cases, advanced practice nurse education results in a master's degree.

Advanced practice nurses are trained to provide from 80 to 90 percent of the necessary primary care services of the nation. Primary care services include: preventive care and screening, physical examinations, health histories, basic diagnostic testing, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutrition issues, minor surgery or assisting at surgery, prenatal care and delivery of normal pregnancies, well-baby care, continuing care and management of chronic conditions, as well as referral to and coordination with specialty caregivers.

Of the 2.2 million registered nurses in the United States, approximately 139,117 are considered advanced practice nurses with this type of advanced education and most are trained to provide primary care services. Some advanced practice nurses are specialized in tasks that are complimentary to primary care, (i.e., certified registered nurse

anesthetists administer anesthetics for patients, including intravenous sedations and some clinic nurse specialists (CNS) specialize in such clinical areas as cardiology, oncology, stoma care, although other CNSs provide direct patient primary care services such as mental health counseling and gerontological care. With this advanced education, many State legislatures have expanded the scope of practice of advanced practice nurses to include such things as prescriptive authority. Furthermore, Federal health insurance programs [i.e., Medicare and Medicaid in certain cases, Federal Employees Health Benefits Program (FEHBP) and CHAMPUS in all cases] directly reimburse advanced practice nurses for their services.

CURRENT NURSING EDUCATION FUNDS UNDER MEDICARE

Since its inception in 1965, the Medicare program has paid a portion of the costs of training health professionals. Graduate Medical Education (GME) expenditures for nursing education are intended to reimburse a portion of the costs of nurse education to promote quality inpatient care for Medicare beneficiaries. Thus, Medicare has traditionally made payments to hospitals for the "training" of nurses in hospital-based nurse education programs. A majority of these programs are hospital-based programs that grant a diploma rather than a Bachelor of Science degree that is granted by most university-based nursing education programs, or an associate degree granted by community colleges. Medicare reimburses hospitals based on a formula payment for a portion of the cost of these hospital operated nurses education programs including classroom and clinical training. In cases where the hospital acts as the training site, but the educational program or institution is separate (but with a written joint venture agreement with the hospital), only the clinical training costs are reimbursed under Medicare. As of 1989, no new jointly operated programs have been eligible for Medicare reimbursement. In 1991, Medicare provided approximately $174 million to hospitals in support of nursing education costs, and these payments were estimated to increase to $248 million last year. In 1991, 144 hospital diploma programs received the majority of this Medicare graduate medical education (GME) funding. Despite this funding source, diploma nursing programs are rapidly disappearing. In 1965, they numbered over 800, but in 1994 only 112 programs remained. The numbers are even more dramatic when examining the relative numbers of total nurses educated through the diploma program. In 1965, 77 percent of all registered nurses were trained in hospital operated diploma programs; by 1990, less than eight percent of all nurses were trained in this manner. Nurse education has shifted almost entirely away from the hospital-based settings to community colleges and universities.

Medicare reimbursement for nursing diploma programs is also centralized in certain regions of the country -- six states (Pennsylvania, Illinois, Ohio, New Jersey, New York, and Massachusetts) received 50 percent of the available funding.

Since the enactment of Medicare, dramatic changes have occurred in the field of nurse education. For example, the financing of nurse education has shifted away from hospital-based diploma programs sponsoring students to the students and their families bearing the brunt of the cost of a higher education nursing program. Furthermore, the locus of educational control has shifted from the hospitals to the educational institutions granting four and six year degrees. For the most part, hospital based nursing programs do not produce primary care providers, but rather these primary care practitioners graduate from four-year BSN programs and advanced nursing educational programs. Advanced practice programs for nurses has increased dramatically in the past decade. Therefore, nursing finds that the primary Federal support for nurse education is based on an outmoded payment system reimbursing those nurse education programs that are least likely to be able to help meet the growing need for more primary care and community-based health are providers.

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Furthermore, Medicare funds for nurse education are not routinely targeted for this intended purpose, but can be diverted to a hospital's general revenue pool and distributed in a variety of manners based on the institution's internal budgeting processes.

THE NEED FOR A GRADUATE NURSING EDUCATION PROGRAM

As the need increases for community-based and primary care providers, nursing will be forced to expand the number and capacity of its graduate level education programs. These programs do not currently receive Medicare funding. In order to educate adequate numbers of skilled advanced practice nurses who provide high quality and cost-effective services to Medicare recipients, there must be a reliable revenue stream that is not subject to the uncertainties of the annual appropriations process. We urge this Committee to redirect, over a three-year phase-in period, a portion of the Medicare funds currently being used to support diploma nursing programs in hospital institutions to programs that educate advanced practice nurses. However, since there is also a continued need for four-year BSN prepared nurses to play a variety of critical roles in the evolving health care system, we believe that the current Medicare funds reimbursing hospitals for those programs should be maintained.

We also believe that funding must be available to the 72 existing programs offering what is termed an "RN to MSN" program. In essence, these are accelerated nursing education programs for diploma or associate degree nurses to become master's prepared and hence, better able to meet the primary health care needs of the nation. These programs allow for a readily-available pool of skilled experienced health care professionals to become educated as advanced practice nurses in a shorter amount of time.

A graduate nurse education program would help many graduate nursing students who are currently attending school part-time due to financial constraints to become full time students. The current cost of attaining a nurse practitioner education is similar to students pursuing master's degrees in other areas of study. A 1994 Lewin-VHI study commissioned by the Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing estimated that the average cost of nurse practitioner and certified nurse midwife programs per student year is $15,591. The average costs for all nurse practitioner programs are $17,544 per student year and $34,096 per graduate.

A large portion of a graduate nursing student's programs are in clinical practice. Some certifying exams require that the nurse graduate spend one-third of his or her advanced nurse education in the classroom and two-thirds in clinical practice, although in most cases, the classroom and clinical studies are integrated through the graduate student's curriculum. *In other words, even as advanced practice nurses are training for their degrees, their services are utilized in providing much needed health care services to patients.*

THE NEED FOR RN's

Recent research by Linda Aiken, PhD, RN, FAAN demonstrates that hospitals have not increased employment of nurses enough to offset the increase in acuity, so nurses are working under greater pressure to provide critical health care services to acutely ill patients. While employment in the hospital sector increased 33 percent during the 1980s and positions for nurses also increased by over 200,000 FTEs between 1980 and 1992, RNs and LPNs exhibited the slowest growth of any occupational category in the hospital workforce. Further, many of the new RN positions were in administrative or other non-clinical roles. Consequently, nurses represented a smaller share of the hospital workforce at the same time that patients in the hospitals were sicker than in previous years; this increasing need for acute health care services fell mostly on the nursing personnel.

Despite the need for nurses to care for sicker patients in the hospital setting and the need for nurses to provide primary care in the community-based settings, the majority of newly graduated nurses (65 percent) graduate from associate degree, community colleges or diploma programs. This mix of nurses by educational background does not reflect the needs of the changing health care market.

THE EVOLUTION OF MANAGED CARE

The health care delivery system is a rapidly changing environment that needs an provider infrastructure to better deliver coordinated quality care in cost effective manner. Medicare has always paid for the training of providers in the hospitals. As health care is increasingly moving to ambulatory care sites and health maintenance organizations (HMOs) are charged with the task of educating the "provider of the future" it follows that new systems must be developed for Medicare to provide clinical training for practitioners in these settings. Managed care plans are hiring new practitioners and developing teams of practitioners including nurse practitioners. Managed care plans are attracting practitioners whose training they have not subsidized. Managed care plans currently neither contribute to this training nor do they qualify for training dollars. Some managed care plans train in-house at their own expense. New systems such as community partnerships will have to be developed between the managed care networks, teaching hospitals and nursing programs. Policy makers must begin to shift a significant amount of training to ambulatory sites in order both to match the training to service and to provide practitioners and site role models for future clinicians to follow.

The delivery of health care serves in this country has clearly moved to ambulatory sites. Changes in hospital admission, use of various ambulatory facilities as well as health expenditures reflect this shift. It is even possible for an increasing number of surgeries to be performed in the outpatient setting. The training of the health practitioner in an inpatient sector is outmoded. In the 19th century individual apprenticeships, training and education moved to group experiences in hospital settings as public hospitals increased in number. After World War II, education become linked to inpatient care and research as Medicare financed support center on inpatient specialty services. Despite the clear and increasing demand for more primary care providers, academic health centers continue to train specialty care physicians and nurses. Because advanced nurse training focuses on the integration of services and developing teams of providers, these practitioners are better suited to community based primary care settings (National Governor's Association Report 1994).

HOW THE PROGRAM WOULD WORK

Medicare funding should be used to meet the health care needs of the future by retargeting the eligible entities for this funding to be educational programs rather than health service providers. ANA proposes that Medicare funds under the Graduate Medical Education program which are currently used to reimburse diploma nursing education be re-directed to graduate nurse education programs that are post-baccalaureate, advanced practice programs accredited by a national accrediting body and linked by a written agreement to an academic institution that is accredited by a national, state, and/or regional accrediting body. A formula- driven payment would be established for the training of the clinical training of advanced practice nurses taking into account the number of annual full-time equivalent participants in the program and the national average of costs of such programs in educating such a participant. Advanced practice nurses currently train in a variety of settings including hospitals, skilled nursing facilities, home health agencies, nurse managed care centers, ambulatory care facilities, health maintenance organizations public health departments and community health centers. Nursing programs and students currently incur the costs for the support of the clinical training of the advanced practice nurse education. Yet, these students are providing direct health care in a manner similar to medical residents. Funds should be available

to nurses in graduate nurse education programs to help them defray tuition and fees and provide student stipends, as well as the costs of faculty supervision at the provider site, and program expenses.

ANA also believes that the classroom costs incurred by rural and urban underserved providers should be considered for reimbursement. It has been demonstrated that nurses often provide care in underserved inner city or rural areas where no other provider is available. Thirty-one percent of all nurse practitioners report that greater than half of their patients are Medicaid recipients and eight percent of all nurse practitioners report that 50 percent of their clients are Medicare beneficiaries. Furthermore, 20 percent of all nurse practitioners report that more than 50 percent of their patients have no source of payments. Nurse practitioners also report that special populations comprised more than 25 percent of their patients in practice including the homeless, victims of abuse, culturally diverse patients with a non-Western orientation to health care, and substance abusers. Many clinical nurse specialists provide psychiatric services. Over 25 percent of all clinical nurse specialists report that greater than half of their patients are Medicaid recipients. Overall greater proposals of nurse practitioners and certified nurse midwives were found in urban undeserved and high poverty areas. Near 19 percent of all certified nurse midwives provide care in high poverty areas compared to 10 percent of all obstetricians/gynecologists. In high poverty areas, nurse practitioners and certified nurse midwives work predominantly in clinics and in rural undeserved areas, more than one third of these practitioners work in rural health centers.

Medicare beneficiaries in inner cities or rural areas are known to be able to access the health care delivery system less than their counterparts in other geographic areas despite the fact that they have a single payer system available to them. As managed care continues to grow and the Medicare system looks toward managed care as the cost saving salvation additional steps will be needed to allow this population to access their services. Advanced practice nurses play a critical role in providing care to the nation's elderly population.

THE NEED FOR RESEARCH

There is a need for additional data on the relationship between the workforce trends and advanced practice nurses. We request that Members of this Committee take the lead in establishing a graduate nurse education council to track workforce trends as they relate to the advanced practice nurse. In tracking such trends, the supply and demand for physicians and other health professionals should be assessed.

CONCLUSION

Mr. Chairman, we thank you for holding these hearings today on graduate medical and nurse education. We applaud this Committee for its strong commitment to the improvement of the health care systems in this country, and we appreciate the opportunity to share our views with you. Thank you.

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Chairman THOMAS. Thank you very much, Ms. Johnson.
Dr. Kalkwarf.

STATEMENT OF KENNETH KALKWARF, D.D.S, DEAN, DENTAL SCHOOL AT THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO, TEX., ON BEHALF OF THE AMERICAN DENTAL ASSOCIATION AND THE AMERICAN ASSOCIATION OF DENTAL SCHOOLS

Mr. KALKWARF. Thank you very much for the opportunity to testify today.

My name is Ken Kalkwarf. I am dean of the Dental School at the University of Texas Health Science Center at San Antonio, and I am here today on behalf of the American Dental Association and also the American Association of Dental Schools.

It is my pleasure to discuss the need for continued and expanded Medicare support for graduate dental education. For almost 30 years, Medicare payments for graduate medical education have been vital to meeting the dental health personnel needs and enhancing the quality of care for Medicare beneficiaries.

The Association's first recommendation is for the continuation of GME funding for hospital-based graduate dental education programs.

Dental residents trained in hospitals have always been counted in GME funding. It is critical that this support continues. GME funding for dental residents is essential to meet the oral health needs of Medicare beneficiaries.

There are many oral health conditions that must be addressed prior to medical treatment of the elderly, the disabled, or the medically compromised. Bacteria from untreated oral infections complicate management of systemic disease and compromise success of medical therapy.

The hospital-based dental programs at my institution train residents in general dentistry, pediatric dentistry, and oral and maxillofacial surgery. The residents within these programs provide consultations for and treatment of patients receiving chemotherapy, head and neck radiation, organ transplants, joint replacement, and cardiovascular surgery, as well as providing consultations for patients with infections or chronic diseases.

In these GME-supported programs, dental and medical residents learn to work together as primary team providers.

The Association's second recommendation is that dental residents be included in direct GME inflationary updates. This would correct a current inequity. In the direct GME formula, primary care dental residency programs do not receive inflationary updates. Without these updates, it becomes difficult to sustain primary care dental residency programs.

Dentistry has few alternative sources of revenue. Many dental residents pay tuition for their postdoctoral primary care training. As a result, primary care dental residents may have educational debts greater than their medical colleagues. The excessive debt burden discourages some students from even applying for postdoctoral training.

The Association's third recommendation is that GME funding be extended to cover nonhospital graduate dental programs. Only

graduate dental programs located in teaching hospitals currently receive Medicare, direct GME, and IME support. This ignores the fact that substantial training takes place outside of the hospital. Dental residents at outpatient clinics provide a significant amount of uncompensated care to elderly and low-income patients, but these programs do not receive GME funding.

We urge the committee to consider providing Federal support to all accredited postdoctoral dental education programs, including those providing only outpatient care.

Mr. Chairman, we want to emphasize that oral health is an integral part of total health, and oral health care is an integral part of comprehensive primary health care. Therefore, graduate dental programs are a vital part of meeting the Nation's health care needs.

However, hospital dental programs and dental school clinics have unique financial problems which make delivering this care difficult. Federal reimbursement for dental services is extremely limited. As a result, hospital dental programs and dental school clinics have become a "safety net" for patients without insurance or resources to pay.

Unfortunately the increasing amount of unreimbursed dental care provided by these training programs puts them at serious financial risk.

A recent Institute of Medicine report recognized the valuable role of graduate dental training and its perilous financial situation. Medicare, DME, and IME are sources of ongoing support for these residency programs. Any significant reduction in direct GME or IME support will cripple the Nation's dental training infrastructure. In fact, without Medicare GME support, many hospital-based dental residency programs would close due to the high cost of training, unreimbursed care costs, and the lack of other funding mechanisms.

In summary, we recommend: First, continuation of GME funding for hospital-based dental education programs; second, inclusion of dental residency programs in the direct GME inflationary updates; and last, extending GME coverage to nonhospital graduate dental programs.

Through such a partnership with Medicare, these programs can continue to play their vital role in meeting the Nation's primary health care needs.

Thank you.

[The prepared statement follows:]

TESTIMONY OF KENNETH KALKWARF, D.D.S.
AMERICAN DENTAL ASSOCIATION

Thank you Mr. Chairman and Members of the Committee for the opportunity to testify today on behalf of the American Dental Association and its 140,000 members. I am Dr. Kenneth Kalkwarf, Dean of the Dental School at the University of Texas Health Science Center at San Antonio.

Introduction

The ADA endorses the goal of the Committee to develop a relevant and long-term policy on the role of Medicare in the support of health professions education. For almost thirty years, Medicare payments for graduate medical education have been vital to meeting the health manpower needs of our country while enhancing the quality of care for Medicare beneficiaries. Since the beginning of Medicare, dental residency training has been part of this funding mechanism. It is essential, we believe, that this assistance be continued. Our views on this important issue are based upon three fundamental propositions:

1) A direct link exists between a financially sound graduate dental education system and the provision of oral health care to the elderly, disabled, medically compromised and other special need populations;

2) Graduate dental education rests upon a fragile economic base;

3) Alternative sources of financing do not exist.

These factors compel, we believe, an adequate and predictable level of federal support through Medicare direct and indirect graduate medical education funding.

Before addressing more specific issues and recommendations with regard to Medicare and Graduate Medical Education payments, I would like to briefly describe the nature of oral health care provided to patients in these dental residency training programs.

Treatment of dental caries (decay) in children was the predominate concern of dentists in the past. Today, as a result of advances made in preventive oral health care over the last four decades, an increasing number of people are retaining their teeth for a lifetime. This change in the nature of dental disease requires today's dentists to master a broader range of treatments and to understand the implications of an ever-increasing number of medical conditions and prescription drugs on the oral health of patients, especially the elderly. Further, there is growing recognition of the importance of providing medically necessary oral health care.

Dental caries and periodontal diseases are bacterial infections which, like pneumonia and other bacterial diseases, require treatment. Oral cancer is more common than most people realize and kills more people each year than cervical cancer. Untreated dental diseases cause millions of hours of lost productivity and impede employability. Oral health affects general health and treatment of dental diseases is often a medical necessity.

For adults without dental coverage or the means to pay for care, teaching hospitals and dental school clinics serve as a dental "safety net". As in medicine, the hospital emergency room is often the major source of oral health care for the poor. The dentists and dental residents in hospitals serve this safety net function, and unless there is a dentist available, patients with dental problems will be given only temporary relief -- the underlying problem, still untreated, will resurface at a later time. Dental staff in these hospitals also provide numerous

consultations, mostly unreimbursed, on medically necessary oral health care needs.

Medically Necessary Oral Health Care

For the **Medicare population**, there are many oral health conditions that must be addressed prior to medical treatment. Medically necessary oral health care is a direct result of, or has direct impact on, an underlying medical condition. It includes care directed toward control and/or elimination of pain, infection, and reestablishment of function. There are a variety of serious diseases and conditions that can be complicated where oral health is not properly attended to.

- For those receiving radiation therapy, a dental abscess or infection frequently becomes uncontrolled and destroys the surrounding bone or even the jaw itself, leading to mutilation and sometimes death. Rampant decay is a common complication due to the destruction of the salivary glands.

- Bacteria from oral infections can spread through the blood stream and attach to heart valves of those with congenital or acquired heart defects and to other prosthetic replacements in patients. This results in death fifty percent of the time.

- For diabetics, any infection can be life threatening, because the infection exacerbates the diabetes and precludes control of elevated blood sugar levels. In this context, it is important to remember that periodontal diseases and dental caries are the most common infections in adults.

- **For those with** a blood disorder, gingival (gum) **bleeding** can be life threatening. Persons at risk **include** hemophiliacs and those with HIV disease.

- **Renal** transplant patients, those on chemotherapy, and anyone with an immune deficiency are vulnerable to the uncontrolled progression of the herpes simplex virus (fever blisters). The virus can spread to the brain and spinal cord in those who are immunosuppressed. When uncontrolled, this often results in death.

- For patients on chemotherapy, oral infections can spread unchecked through the blood stream because of the absence of natural defenses. Mouth infections are the most common infections in chemotherapy patients and are therefore a major cause of life threatening disease in these patients.

Unfortunately, many of the above services are provided without reimbursements from federal fundings or any other sources. Because Medicaid dental services for adults are optional rather than mandated, some states provide no dental coverage for adults and most of the remainder provide only emergency treatment or very limited restorative services. In addition, more states are considering eliminating adult dental services as the country's economic situation continues to strain state budgets. New York State would be an example.

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Under Medicare part B, the dental care covered is extremely limited (essentially limited to treatment of traumatic injuries, oral pathology, and jaw surgery). Hospital dental programs cannot rely on Medicare patient revenues to support the programs. As a result, dental residency programs, which serve both the training function and a necessary patient care function, often provide free care because oral health services are not reimbursed.

Dental Residency Training: An Overview

Training for dental school graduates at the postdoctoral level (after dental school graduation) takes place at both dental school clinics and teaching hospitals. The programs that are relevant for discussion of Medicare DGME and IME are the eight recognized dental specialty programs and General Dentistry residency training programs. In 1993, the first year enrollment for all of these programs was 2,447, representing sixty five percent of the dental school graduates for that year. Unlike medicine, there are not enough dental residency positions for all dental school graduates.

The postdoctoral programs and their first year enrollment figures for 1993 are as follows:

Type of Program*	1st Yr. Enrollees (1993)	Length of Training (years)
Dental Public Health	17	1 or 2
Endodontics	155	2
Oral Pathology	8	3
Oral Surgery	213	4
Orthodontics	266	2
Pediatric Dentistry	173	2
Periodontics	188	3
Prosthodontics	201	3-4
General Dentistry	1,224	1-2

* A description of the various residency programs is appended.

General Dentistry training programs provide a one to two year clinical and scientific experience which provides residents with additional expertise in various dental specialties and hospital dentistry. General Dentistry residents learn to care for the oral health needs of those requiring specialized or complex care, such as the handicapped, developmentally disabled individuals, high risk medical patients, and those with infectious diseases. As a result, graduates of these programs refer to specialists less often, which is critically important in rural and underserved areas. Eighty seven percent of those trained in General Dentistry residencies remain in primary care practice. In 1993, there were 1,224 first year enrollees in these programs, but demand remains high as twenty five percent of the applicants were turned away.

Dental residency training also differs from physician training in that approximately one half of all positions are located in dental schools; the other half are in hospitals. Dental school clinics are not eligible for Medicare DGME funding. Of hospital dental training sites, only non-VA, non-DOD teaching hospitals receive DGME support. In 1993 approximately forty four percent of all postdoctoral dental residency training positions took place in hospitals supported by Medicare DGME and IME funding.

What does this mean in terms of federal support? One of the recommendations of the Institute of Medicine's recent study of dental education ("Dental Education at the Crossroads", released

January 17, 1995) directly addresses postdoctoral dental training policy:

> "The Committee recommends that postdoctoral education in a general dentistry or specialty program be available for every dental graduate, and that the goal be to achieve this within five to ten years, and that the emphasis be on creating new positions in advanced general dentistry ..." (Recommendation 7)

The Association would support the establishment of additional positions sufficient to meet need or demand.

Because Medicare DGME and IME funding provides for ongoing maintenance of these programs, continued inclusion of dental training in these formulae helps to maintain the hospital-based postdoctoral training positions that currently are provided. The Association also supports funding for start-up costs of such programs. This is critically important in assuring comprehensive care to patients and to the availability of a workforce able to meet the broad spectrum of patient needs.

Medicare DGME and IME: Impact on Dental Education and Needed Improvements

Given limitations in oral health care coverage described earlier, it is clear that patient care revenue is not sufficient to support dental residency training programs. Significant support from a host institution is required, and even the Medicare GME and IME that teaching hospitals receive can only meet a portion of the total costs.

While Medicare DGME and IME funding streams currently flow to the teaching hospital administration rather than directly to residency training programs, their continuance is vitally important to dental programs. If the dental residency training position "counts in the formula", there is less financial pressure from the hospital administration or threat of program closure. Often, directors of dental residency programs can point to such offsetting funds in making the case for continuation of their programs. These programs are often in a deficit situation absent such DGME/IME support, due to the indigent unreimbursed oral health care that is provided.

A 1994 survey of Medicare GME and IME's impact on 235 hospital dental training found that thirty percent have been threatened with closure due to financial hardship. These Medicare funds help the programs to continue despite an average thirty two percent shortfall in revenues to expenses.

Medicare Direct GME (DGME): DGME payments are based on a formula of full-time equivalent (FTE) residents multiplied by a per resident dollar amount and then multiplied by the proportion of hospital inpatient days used by Medicare patients in the particular hospital. Since the beginning of Medicare, hospital dental training has been part of this funding mechanism.

Under HCFA regulations, the GME formula counts a full-time resident for the time spent in a basic training period plus one year (basic training period means the time required to be eligible for board certification). The regulations make an exception for General Dentistry residencies, so these primary care residents are counted in the formula even though the training is not required for board certification (Federal Register, September 29, 1989, p. 40294). The other basic training periods (plus one year) for dental residencies are: Endo-3 years, Oral Path-4, OMFS-5, Ortho-3, Pediatric-3, Perio-4,

Prosth-4, Prosth Max- 5.' Only hospital-supported dental education programs receive this Medicare payment. Dental school-based residencies are not part of this reimbursement formula. Offsite residents can also be counted if the hospital incurs all or substantially all of the costs of such training.

Medicare Indirect Medical Education (IME): As the Committee is aware, the IME adjustment is provided to teaching hospitals to compensate for factors that increase their costs, such as a more severely ill patient population, severity of cases and weakness of the DRG system in recognizing this, and operating costs associated with education programs. As with Direct GME, IME payments are only made to teaching hospitals, and dental residents in hospitals count in the formula.[2]

There is movement toward having more training take place in outpatient or other ambulatory care settings. Innovative dental programs have been established at some hospitals, where dental residents rotate through community health centers. OBRA '93 allows residents in community health centers to be counted under IME if the residents are under the hospital's ownership or control and the hospital incurs all or substantially all of the costs of services furnished by interns and residents. Therefore, it is important for dental residents to continue to count in this formula. The ADA encourages expansions of General Dentistry training sites. These sites provide primary dental care to the unserved and underserved population. It is not possible to promote training in the ambulatory care setting without dental residents in the formula.

Problems and Recommendations:

While continuation of current Medicare DGME and IME funding is vitally important for dental education, there are two additional issues of concern that should be addressed:

(1) Dental programs do not receive an inflationary update under DGME; and

(2) Dental school-based residency programs receive no DGME support.

The Budget Reconciliation law of 1993 (OBRA 1993) defined primary care residencies as family medicine, general internal medicine, general pediatrics, preventive medicine, geriatric medicine, or osteopathic general practice. This medical-only definition reflected a goal to steer more physicians into primary care. The law provided that only these primary care residency positions would receive an annual inflationary update of the per residency amount in the Direct GME formula.

Unfortunately, this completely overlooks the critical primary health care role played by dental residents. For most Americans, the primary care team includes a physician and a dentist. If either is unavailable, the patient has an access problem, as treatment of the entire body must include the oral cavity. The incomplete definition of primary care used for the inflation update was taken from a Public Health Service training definition explicitly limited to a medical loan program. In fact,

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'The citation for inclusion of hospital dental residents in Medicare DGME is: 42 CFR (Code of Federal Regulations) § 413.86, referencing § 405.522 (a).

'The citation is 42 CFR § 412.105 (g)(1)(A), referencing § 405.522 (a).

contemporaneous report language accompanying the 1992 reauthorization of health professions programs shows that the committee recognized dentistry as a primary care component of practice:

> "The Conferees have tied receipt of Federal scholarship funds to the completion of primary care training programs and the practice of primary care . . . After graduation from allopathic or osteopathic schools of medicine or dental school, the individual must enter general dentistry practice, or will have five years to complete a residency program in either family medicine, general pediatrics, general internal medicine, or general dentistry."

The recent IOM report on dental education specifically states, under the first of eight "Policy and Strategic Principles" that **"[o]ral health is an integral part of total health, and oral health care is an integral part of comprehensive health care, including primary care."**

Further, if GME policy is further modified to "weight" or re-direct DGME funds toward "primary" care, **use of this same definition would cripple the dental residency training infrastructure of this country.**

While policymakers may be pleased to know that dental education does not have such a specialty oversaturation problem as in medicine, we urge that Congress not adopt policies that might disrupt the balance that has been maintained, and we urge support for development of generalists.

At the very least, General Dentistry and Pediatric Dentistry residency training should be included in any primary care funding preference because they are the dental parallel to family medicine and pediatric medicine. Oral and maxillofacial surgeons also play a primary care role when they are the only dental residents in a hospital, and their training programs should be supported.

We would like to work with the committee to correct the inflation update problem, and with regard to any other funding preferences that may be proposed.[1]

Our second recommendation is to correct the inequity that has long existed under Medicare DGME, by extending support to dental school-based residency programs. This would recognize the role that dental school-based residents play in treating underserved populations, including low income and elderly patients. A recent preliminary study of dental school clinics prepared for the American Association of Dental Schools (AADS) found that the median household income of clinic patients was $13,800 -15,600 per year, with two-thirds reporting a household income of $20,000 or less. Eighteen percent of the patients were age 65 and over. AADS estimates that over 600,000 Medicare eligible individuals are treated each year in dental school clinics. It is sensible federal policy for Medicare to pay its fair share of these training costs.

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[1] If the statute is amended this year there should also be a technical correction to delete references to programs that are "approved by the Council on Dental Education of the American Dental Association" existing language from the Medicare statute and regulations (42 CFR § 405.522 (a)). The Council on Dental Education no longer "approves" programs. In 1975 the Commission on Dental Accreditation (CDA) became the accrediting agency for dental, most postdoctoral, and allied dental education programs.

For federal health professions training policy, the ADA recommends that Medicare's DGME support be expanded to all accredited postdoctoral dental programs.

Thank you Mr. Chairman for your consideration of the Association's recommendations. I would be pleased to answer any questions at this time.

Chairman THOMAS. Thank you very much, doctor.

Dr. Jones, if you would allow us to catch this vote and then come back, we would be pressed if we gave you the full time for your testimony, and I want to, so if you would allow us, the subcommittee will stand in recess until we hurry back.

[Recess.]

Chairman THOMAS. The subcommittee will reconvene. And, Dr. Jones, you may proceed.

STATEMENT OF CHARLES L. JONES, D.P.M., PRESIDENT, AMERICAN PODIATRIC MEDICAL ASSOCIATION

Mr. JONES. Thank you. Mr. Chairman, members of the subcommittee, I am Charles Jones, president of the American Podiatric Medical Association.

As one who has devoted much of his professional life in postdoctoral podiatric medical education, I welcome this opportunity to appear before this subcommittee today on the subject of graduate medical education, a vision for the future.

It is my purpose, Mr. Chairman, to acquaint the subcommittee with podiatric's role in GME and why continued Federal participation in graduate medical education is vital if high-quality health and medical services are to be maintained and strengthened.

Since January 1, 1973, following the Social Security amendments of 1972, postdoctoral residency programs in podiatric medicine and surgery have benefited from both direct and indirect GME payments under Medicare. Based on our best available information, we estimate that as of November 1994, 210 teaching hospitals with 800 residency slots in 29 States and the District of Columbia received Medicare payments for the direct costs of these programs.

Additionally, 46 VA hospitals and 3 military hospitals additionally train 160 podiatric medical residents, although these training programs are funded by those Federal agencies, not Medicare.

Suffice it to say that we believe very strongly that podiatric medical residency programs must continue to have access to funding, including access to any new funding mechanisms that ultimately replace or supplement that currently in effect under Medicare.

Among other things, completion of an approved residency program is now seen as an essential component of training of a doctor of podiatric medicine. A 1992 resolution adopted by the American Podiatric Medical Association house of delegates, for example, makes clear that colleges of podiatric medicine should prepare their graduates for entry-level postgraduate study, not for entry-level practice.

Equally important, an increasing number of States have begun to require a minimum of 1 year postgraduate education or residency for licensure as a doctor of podiatric medicine. As of 1994, 35 States imposed such a requirement.

The basis for any change in GME financing schemes begins with the well-known fact that there are considerably more allopathic medical residency positions than there are graduates of U.S. schools of medicine with these excess positions being filled by foreign medical graduates.

For example, the Council on Graduate Medical Education has suggested limiting the number of residency positions to 110 percent of the number of allopathic medical school graduates.

In the case of podiatric medicine, however, there are no foreign medical graduates. Since to practice in the United States one must have had to successfully complete a course of study at one of the seven U.S. colleges of podiatric medicine.

Hence, the profession's longstanding goal has simply been to provide an adequate number of residency positions to accommodate all graduates of its colleges. This goal was finally achieved in 1991.

But as recently as 1988, there were only enough residency training positions to meet the needs of about 69 percent of the podiatric medical college graduates. And this year we again expect to fall short of being able to fulfill about 10 percent of our postdoctoral training program needs.

Thus, unlike allopathic medicine, there are no excess residency positions, and the positions which do exist are filled by graduates of U.S. colleges of podiatric medicine.

A second premise some employ in debating the need to alter graduate medical education payment schemes is that there are too many allopathic and osteopathic physicians.

The Council on Graduate Medical Education has spent considerable time and effort attempting to document physician supply and demand and identifying the types of allopathic and osteopathic physicians expecting to be in an oversupply in the coming years.

In contrast, the Council on Graduate Medical Education has not examined the supply of and demand for podiatric physicians. In fact, no government body has determined that an excess supply of doctors of podiatric medicine is in the offing.

In 1981, the U.S. Department of Health and Human Services established an ideal ratio of 6.2 podiatric physicians per 100,000 population.

Much more recently the Bureau of Health Professions of the U.S. Public Health Service contracted with the National Center for Health Statistics to obtain baseline data on foot care needs in the general population. This was done as part of a 1990 national health interview survey.

In comparison, podiatric physicians accounted for 4.5 percent of all medical and surgical services provided to Medicare patients by all physicians in 1991. Doctors of podiatric medicine, in fact, provided the majority of foot care services needed by Medicare beneficiaries, and this population continues to increase about 2 percent per year.

In conclusion, Mr. Chairman, the Association does not envy the difficult but necessary task this committee, indeed, has. The Congress faces encountering the Nation's enormous debt and its mounting annual deficits. Sacrifices, we know, will be required of each of us if these larger issues are to be successfully addressed.

But if future generations of Americans are to be guaranteed appropriate access to well-trained physicians, it is absolutely essential that we maintain and strengthen our medical education system, including its residency training component. Postdoctoral residency training, including its supervisory component, requires substantial time and commitment and must be compensated.

The American Podiatric Medical Association believes that all third-party payers, including Medicare, should proportionally share the cost of supervision and related educational costs. This is absolutely essential to help ensure high-quality patient care and to preserve high-quality postdoctoral training.

Thank you.

[The prepared statement follows:]

TESTIMONY OF CHARLES L. JONES, DPM
AMERICAN PODIATRIC MEDICAL ASSOCIATION

Mr. Chairman, Members of the Subcommittee:

I am Dr. Charles Jones, President of the American Podiatric Medical Association, and a private practicing podiatric physician in Chicago, Illinois. As one who has devoted much of his professional life in post doctoral podiatric medical education, I welcome this opportunity to appear before this subcommittee today on the subject of Graduate Medical Education (GME) -- A Vision for the Future. It is my purpose, Mr. Chairman, to acquaint the subcommittee with podiatric medicine's role in GME and why continued Federal participation in graduate medical education is vital if high quality health and medical care services are to be maintained and strengthened.

Podiatric Medicine and GME

As you noted in the press release announcing today's hearing, Medicare has since its inception reimbursed teaching hospitals for the program's share of costs for the training of physicians and other health professionals. But it was not until the Social Security Amendments of 1972 that podiatric physicians became eligible for Medicare's GME benefit. Since January 1, 1973, post doctoral residency programs in podiatric medicine and surgery have benefited from both direct and indirect GME payments stemming from Title XVIII. Based on our best available information, we estimate that as of November, 1994, 210 teaching hospitals with 800 residency slots in 29 states and the District of Columbia received Medicare payments for the direct costs of these programs. Additionally, forty-six Veterans Administration hospitals and three military hospitals additionally train 160 podiatric medical residents, though these training programs are funded by those Federal agencies, not Medicare.

Suffice it to say that we believe very strongly that podiatric medical residency programs must continue to have access to funding,

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including access to any new funding mechanism that might ultimately replace or supplement that currently in effect under Medicare. Among other things, completion of an approved residency program is now seen as an essential component of the training of a doctor of podiatric medicine. For example, a special consensus panel convened in March, 1992, by the Liaison Committee on Podiatric Medical Education and Practice concluded that "One year of 'postgraduate' training is necessary to enter either the private practice of or advanced specialty training in podiatric medicine." Further, a 1992 resolution adopted by the APMA House of Delegates makes clear that colleges of podiatric medicine should prepare their graduates for entry level postgraduate study, not for entry level practice. Finally, an increasing number of States have begun to require a minimum of one year postgraduate education or residency training for licensure as a doctor of podiatric medicine (DPM). As of 1994, 35 States imposed such a requirement.

Restructuring GME Financing

The basis for any change in GME financing schemes begins with the well known fact that there are considerably more allopathic medical residency positions than there are graduates of U.S. schools of medicine, with these "excess" positions being filled by foreign medical graduates. For example, the Council on Graduate Medical Education (COGME) has suggested limiting the number of residency positions to 110 percent of the number of allopathic medical school graduates.

In the case of podiatric medicine, however, there are no foreign podiatric medical graduates, since to practice in the United States one must have successfully completed a course of study at one of the seven U.S. colleges of podiatric medicine. Hence, the profession's longstanding goal has simply been to provide an adequate number of residency positions to accommodate all graduates of its colleges. This goal was finally achieved in 1991; but, as recently as 1988, there were only enough residency

training positions to meet the needs of about 69 percent of podiatric medical college graduates. But this year we again expect to fall short of being able to fulfill about 10% of our post doctoral training program needs. Thus, unlike allopathic medicine, there are no "excess" residency positions; and the positions which do exist are filled by graduates of U.S. colleges of podiatric medicine.

Assuring a match between the number of residency positions and the number of podiatric medical college graduates has been complicated somewhat, due to a decline in the applicant pool, by relatively recent fluctuations in first year enrollments in the nation's podiatric medical colleges. For example, while first year enrollments gradually rose throughout the first half of the 1980's to peak at 815 in 1986, the number of such students had declined to 561 by 1990. Of note, the Seventh Report to the President and the Congress on the Status of Health Personnel in the United States, March 1990, argued that one reason for the declining enrollments was "applicant awareness of an insufficient number of residency slots to accommodate graduates."

A second premise some employ in debating the need to alter graduate medical education payment schemes is that there are too many allopathic and osteopathic physicians. The Council on Graduate Medical Education has spent considerable time and effort attempting to document physician supply and demand, and identify the types of allopathic and osteopathic physicians expected to be in under - or oversupply in the coming years.

In contrast, the Council on Graduate Medical Education has not examined the supply of, and demand for, podiatric physicians. In fact, no government body has determined that an excess supply of doctors of podiatric medicine is in the offing. In 1981, the U.S. Department of Health and Human Services established an ideal ratio of 6.2 podiatric physicians per 100,000 population. This ratio was

developed as part of the Health Professions Requirement Model, a Federal econometric study. In comparison, the actual 1991 ratio was about 5.0 podiatric physicians per 100,000 population.

Much more recently, the Bureau of Health Professions of the U.S. Public Health Service contracted with the National Center for Health Statistics to obtain baseline data on foot care needs in the general population. This was done as part of the 1990 National Health Interview Survey. This survey of 46,476 households, comprising 119,631 individuals, found that one of every six Americans suffered from foot problems in the twelve months preceding their interview and one of every sixteen Americans deemed their problem serious enough to consider getting professional care. However, more significantly, only 55 percent of those who considered their foot problem serious enough to warrant professional care actually received such care. Of these, 47 percent were seen by a doctor of podiatric medicine for an estimated total of more that 14.5 million patient visits.

In comparison, podiatric physicians accounted for 4.5 percent of all the medical and surgical services provided to Medicare patients by all physicians in 1991. Doctors of podiatric medicine, in fact, provide the majority of footcare services needed by Medicare beneficiaries, and this population continues to increase by about 2 percent each year. For example, in 1991, doctors of podiatric medicine performed 98.5 percent of nail debridements, 82.3 percent of hammertoe operations, 72.5 percent of bunionectomies, and 55.4 percent of rearfoot surgery required by Medicare beneficiaries.

The third premise underlying proposed changes in graduate medical education financing and related initiatives is that there are too many specialists and not enough primary care practitioners. While podiatric medicine is not included in the list of primary care specialties cited in a variety of Federal statutes, the

reality is that doctors of podiatric medicine "often serve as the entry point into the health care system for patients with systemic diseases that manifest themselves by symptoms in the feet," as emphasized most recently in the Eighth Report to Congress on Health Personnel in the United States, published September, 1992, by the U.S. Department of Health and Human Services. Doctors of podiatric medicine also provide a large number of primary care services (as defined in section 1842(i) (4) of the Social Security Act). In fact, evaluation and management services accounted for about 24 percent of the Medicare allowed dollars paid to doctors of podiatric medicine in 1991. Further, the Health Professions Education Assistance Act, when reauthorized in November, 1988, specifically included support for new primary care residency training programs in podiatric medicine. Ten such programs were initially funded, under which about 44 residents are being trained each year. Finally, among the three recognized specialty boards in podiatric medicine is the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

In short, it would appear that two of the premises underlying proposed changes in graduate medical education financing--excess number of residency positions and practitioner oversupply--do not apply to podiatric medicine. The third--the need for more primary care practitioners--may have unique implications in the case of doctors of podiatric medicine. We believe that policymakers should be mindful of these distinctions as they weigh the need to alter support for graduate medical education.

CONCLUSION

To conclude my testimony, Mr. Chairman, the Association does not envy the difficult but necessary task this committee, indeed, the Congress, faces in countering the Nation's enormous debt and its mounting annual deficits. Sacrifices, we know, will be required of each of us if those larger issues are ever to be

successfully addressed. But if future generations of American are to be guaranteed appropriate access to well trained physicians, it is absolutely essential that we maintain and strengthen our medical education system, including its residency training component. Post doctoral residency training, including its supervisory component, requires substantial time and commitment and must be compensated. The APMA believes that all third party payers, including Medicare, should proportionately share the costs of supervision and related educational costs. This is absolutely essential to help ensure high quality patient care and to preserve high quality post doctoral training programs.

Chairman THOMAS. Thank you, Dr. Jones. You indicated that podiatric doctors receive their training in other Federal funded programs other than obviously through the graduate medical education structure?

Mr. JONES. In the V.A. hospitals and the military.

Chairman THOMAS. And, Dr. Kalkwarf, I assume dentists are involved in that as well?

Mr. KALKWARF. Yes. We have some individuals who do train through DOD funding or VA funding.

Chairman THOMAS. A rough percentage?

Mr. KALKWARF. Approximately half of dental residents will be provided training through some sort of Federal support, about 44 percent through GME funding, a small percentage of DOD and VA, and then the other half are funded privately.

Chairman THOMAS. OK. So about, well, less than 10 percent of those that get to Federal funding come into those other programs.

Ms. JOHNSON. Approximately.

Chairman THOMAS. So the bulk come from GME funding.

We have been supplying this graduate medical education funding obviously since—well, for more than a decade, more than two decades actually.

Is the thrust of your statement that there are not enough residency slots for you folk and that we should give more money so that there would be more slots?

Mr. JONES. There are not enough podiatric residency slots for all the current graduates. And, of course, then you fall into quality of program. We have, the profession——

Chairman THOMAS. But if we put more money into it, does that then produce more slots? If someone is controlling the determination of who gets what slots, and there are not enough slots now, why is adding more money going to produce the slots?

Mr. JONES. It would not necessarily do that. We have spent the last 10 years educating the hospitals to the direct and indirect costs through Medicare, and that is how we have increased the number.

Chairman THOMAS. That is my connection. We have got to work on the folks who are writing programs——

Mr. JONES. That is right.

Chairman THOMAS [continuing]. In terms of the importance both of the dentistry and the——

Mr. JONES. That is correct.

Chairman THOMAS. Now in relation to that, where do you folks fall in this movement toward managed care? Is there—is dentistry being incorporated as part of that?

It would seem to me that if you have a managed care program with a decent preventive care program, dentistry is going to be a key part of that. Am I wrong?

Mr. KALKWARF. No. In certain parts of the country, managed care is starting to play a role. In other parts, it is not. It is lagging behind the medicine managed care model that we are seeing progressing throughout the country.

You know, it is our premise that we need to train individuals in dental education and the general practice programs and the dental specialty programs to be able to function within a managed care market, as well as the private market also, because we are going to have a mix in the future obviously.

[The following was subsequently received:]

ADA

Washington Office

April 10, 1995

The Honorable William Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Thomas:

The American Dental Association appreciates the recent opportunity to testify before the Subcommittee concerning future support for Graduate Medical Education.

During the course of the March 23 hearing, you asked several important questions regarding dentistry and managed care. The issues raised are timely and relevant to the debate on health system reform. Your inquiry is particularly appropriate as individual States seek to convert their Medicaid programs into capitated systems.

The purpose of this letter is to briefly expand upon our responses provided at the hearing. We hope the following, additional information will be of value to the deliberations of the Subcommittee.

Dentistry and Managed Care

The Association believes that Congress must understand and accommodate the significant differences between medicine and dentistry as it addresses the issue of managed care. Dental disease is chronic, progressive and destructive. It is also almost entirely preventable through regular examinations and early interception. Americans saved nearly $100 billion in dental care costs during the 1980's through the profession's emphasis on preventive oral health measures. Managed care in the capitated model is designed to respond to and treat medical diseases; conditions which are generally episodic, but also potentially life-threatening and catastrophic in cost.

A basic element of managed care is the gatekeeper. This concept is designed in part to "guide" the patient through the maze of physician specialty and subspecialty care. By contrast, 80% of dental services are provided at one site by one primary care practitioner.

Dentists, of whom over 80% are primary care providers, already serve as gatekeepers for the patient when referrals are necessary.

Most telling, however, is the underlying incentives in the managed care model to limit utilization. This is a consequence of a financing system which--absent deductibles, copayments and other out-of-pocket expenses--often insulates the patient from economic decisions regarding health care services. Gatekeepers, limited choice of practitioners, designated sites for care and lower, capitated reimbursement rates for participating providers can serve as the cost-containment mechanism by creating barriers to patient care.

In contrast, the traditional fee-for-service dental model is cost-effective because it (1) encourages patient visits to prevent oral disease and allow early therapeutic intervention, and (2) involves consumers directly in the cost of dental care. Today's patients pay almost 53 percent of the national dental bill out-of-pocket. The result is, at once, a dramatic rise in the oral health status of those who receive regular dental care and a steady decline in expenditures for dental services as a percent of total health care spending.

The American Dental Association respectfully requests the inclusion of this letter in the formal hearing record of March 23, 1995.

Sincerely,

Dorothy Moss
Director
Washington Office

DM:SK:klp

Chairman THOMAS. And do you think you would be helped if there was a clear focus on a bank of specialists available to back up the gatekeepers in their decisions as to which path an individual should take in terms of whether or not it is, first of all, mental, physical, and then whether or not dental would assist?

I would assume that to the degree we have the opportunity to fall back on—in fact, rely on—second opinions, if you will, within the managed care structure, that you folks would then be seen to be more valuable than you would otherwise.

Mr. KALKWARF. One thing we have to remember is that in dentistry, as compared to medicine, the majority of our practitioners are general practitioners; 80 percent of them are general practitioners. So we do not see the same type of mix in the relationship on the dental side that we do on the medical side at this point in time.

Chairman THOMAS. But when I say "specialty," I really mean specialty as dentists versus others, and that perhaps some of that dental work might be necessary to deal with, you know, symptomatic relief rather than others.

What about podiatric medicine? How is that fitting in in managed care?

Mr. JONES. Throughout the United States, there are quite a few podiatrists on panels and in managed care. But proportionally, they are really squeezed out. And they are especially squeezed out if the managed care organization has financial incentives to the primary care physician, because they do not refer, no matter what.

I have attended several meetings where now the primary care physician is expected to treat most of the common medical conditions—I am not talking about just feet—for at least two or three or four visits until they are assured that they need other triage.

Well, if you are going to keep the patient for three or four visits, the average practitioner outside is not going to get that patient at all.

Another thing that they are doing, another wrinkle that is coming, is that the family practice people are hiring physician assistants and nurse practitioners to administer the more common care, billing at a lower service code, and that lowers the cost.

So there are many factors out there that are affecting the ability of the ordinary practitioner to participate in managed care.

Chairman THOMAS. But you are not opposed, are you, to someone who is adequately professionally trained to perform a service, that if it is not necessary to have a medical degree to perform, that they ought to be allowed to perform it, are you?

Mr. JONES. As long as it is quality work and you are not, you know, going to endanger the patient.

Chairman THOMAS. Of course.

Mr. JONES. I think there are concerns now, and I think some of the panelists this morning said that the primary care physician is not trained in all the conditions. And the managed care organization is suggesting that they go back for a mini-residency, so that they are more adept at treating these things.

And I think you will see that medically, legally, they are going to make some mistakes, which would be normal, and as soon as they lose—as far as podiatry, as soon as they lose a couple of legs—and a leg now is worth about $1 million here in the States—I think

there will be, you know, really some concerns about what they are doing.

Chairman THOMAS. OK. I was going to try to move, then, over to Ms. Johnson, because clearly their concern is that there are a number of things that can be done by professionals in the health care industry that are not allowed to be done or historically have not allowed it to be done because of the historical role of the doctor.

But I guess, Ms. Johnson, my question to you is: Why should we elevate the training of these folk when we have in certain areas—and I guess anesthesiologists would be my best example—why should we take some of these folk and give them advanced training in anesthesia when we already have anesthesiologists who are out of work?

And it seems to me that in moving this structure, you move this way, you have got folks who are getting better training if you had room for those folks who move up. But you do not; they are out of a job.

Why should you not just as easily move in this direction and have doctors performing functions that historically doctors tend not to perform, because they would not have a job otherwise?

And frankly my goal is to push ends this way and provide more folk in that edging between doctors and health professionals in more of that managed care setting that can perform more.

And I think your goal is similar to theirs in terms of finding slots and educational positions for these people who can pursue this advanced training.

In the Medicare area, what percentage—ballpark, if you do not have it fairly precisely—or give me some general feeling of the proportion or percentage of Medicare patients that receive their care from these advanced practice nurses. Do we know?

Ms. JOHNSON. In terms of percentages, it would be difficult for me to even "guesstimate."

I will tell you a large percentage of advanced practice nurses provide gerontological care. We focus a lot in terms of our primary care—our transition to managed care has probably been easier in some aspects because we have always focused on prevention and health maintenance, so-called wellness care, as opposed to always focusing on illness care.

So when you talk about the fact that, for example, with registered nurse anesthetists, someone mentioned earlier that the largest percentage, somewhere in the neighborhood of about 80 percent of anesthetic services in rural areas where there is a great need for care, is provided by nurse anesthetists.

I think there is enough work, enough care needs, given our Nation's status related to health care at this point, that a collaborative approach that involves all of us—and I think you mentioned this a while ago—is the most effective way of approaching it, as opposed to saying one discipline needs to do it all, and others do none.

Chairman THOMAS. Then if you have got doctors who are out of work, but they choose not to move where the work is, and the nurses do, that is a decision in the marketplace.

What about home health care? Is that an area that looks to you folks as a really growth market?

Ms. JOHNSON. As a matter of fact, one of the things that we are focusing on in nursing is the fact that a lot of health care is moving from the hospital into the community.

In listening to the comments of nurses, one of the reasons that the BSN-prepared nurse and the advanced practice nurse are such critical pieces to health care delivery is that a lot of their focus is on moving that health care from the hospital into the community and into home health, into the workplace, into familiar community settings that make it easier to ensure access to health care.

Chairman THOMAS. And not only the traditional caring and supportive role, but the manipulation of various devices, infusion and others, which I think is a kind of a natural fitting. If you are going to have somebody drop by the home, they are going to have to have a degree of that training.

Ms. JOHNSON. It certainly is more cost effective, yes.

Chairman THOMAS. Yes, yes. Does the gentlewoman from Connecticut have anything?

Mrs. JOHNSON OF CONNECTICUT. I appreciate your testimony.

And hearing in the context of our responsibility to better fund medical education the spectrum of training situations that we have to be certain that the new system will meet, I think your testimony is evidence of how hard it has been to break into the existing system, and really at what risk, your training where it has broken in—to what degree it still is at risk, particularly in a period in a change.

So I think your testimony will be very useful to us and is further proof that we need to have a more uniform systemic approach to fostering the development of medical knowledge amongst practitioners and enabling the system thereafter to better integrate skilled practitioners into systems of care that can deliver appropriate and affordable care.

And I appreciate your testimony today.

Chairman THOMAS. With that, I want to thank the panel for your patience as well. The information was very, very helpful to us.

And the subcommittee stands adjourned.

[Whereupon at 1:35 p.m., the subcommittee was adjourned.]

[Submissions for the record follow:]

AMERICAN OSTEOPATHIC HEALTHCARE ASSOCIATION

Statement of
THE AMERICAN OSTEOPATHIC HEALTHCARE ASSOCIATION
For the Record of the March 23, 1995 Hearing
on Graduate Medical Education
Subcommittee on Health, Committee on Ways and Means
U.S. House of Representatives

The American Osteopathic Healthcare Association represents osteopathic hospitals and related institutions nationwide. Seventy percent of our member hospitals sponsor one or more graduate medical education (GME) programs. We are vitally concerned with GME training and believe it is essential that Medicare continue to support it as competitive pressures drive third-party payments downward, thus virtually eliminating whatever support the private sector has heretofore implicitly provided for graduate medical education.

We believe that osteopathic GME programs are especially worthy of support and that harm to them would be a loss to the Nation. Most of these programs are community-hospital based. They train generalist (as well as specialty) physicians in the type of environment in which they will eventually set up practice rather than in a distant tertiary-care medical complex. Our programs turn out a high proportion of primary care physicians. Nearly 60 percent of osteopathic physicians practice in primary care fields. And osteopathic physicians are more likely than their MD counterparts to practice in underserved areas.

We believe that, ideally, all those who pay for health care services should explicitly contribute toward the cost of graduate medical education, but we recognize that an all-payer approach is not likely to be part of whatever incremental health care reform the Congress will adopt in the near future. Therefore, we assume that the issue now is what Medicare's policy toward GME will be during a period when it is necessary to make significant reductions in Medicare program cost.

Recognizing that the area of graduate medical education will not escape budget cuts, we believe that the cuts should respond to physician workforce concerns. A major problem is an overall excess supply of physicians. From the standpoint of both workforce policy and Medicare cost control, there is cause for concern regarding the continuing increase in the total number of residency positions that Medicare is supporting. The Council on Graduate Medical Education (COGME) has recommended an annual limit on the number of first-year residency positions equal to 110 percent of the number of medical school graduates (allopathic and osteopathic). If this recommendation were applied to Medicare funding, it would produce significant savings over present policy, which provides financial support for whatever residency positions are actually filled.

It is important to recognize that international medical graduates (IMGs) make up a major part of the increased number of residents-in-training. For 1993-94, IMGs were about 39 percent of residents. For 1990-91, they were about 30 percent. It is time to recognize specifically that the large numbers of international medical graduates is a problem for physician workforce policy and for Medicare payment policy. One way to respond would be to limit Medicare support to 110 percent of medical school graduates and to specify that the additional 10 percent is for IMGs. Room would be provided for 100 percent of American graduates. Without this specification, limiting the overall number of supported positions might mean depriving some American graduates of training positions while providing them to IMGs. There is little reason to do that, since we know that the quality of American medical school training and its graduates is universally high, which can not be said with the same confidence regarding IMGs and their training. In imposing a 110 percent limit, Medicare would be acting as a prudent purchaser and would be doing so in a way that is consistent with the physician workforce needs of the Nation.

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We also encourage the Subcommittee to consider three GME policy changes that make sense and that can be accomplished within an overall policy of spending reduction.

- **Indirect medical education adjustment:** Consider redesigning the adjustment to eliminate the tie to inpatient beds, a tie which seems inappropriate as both the appropriate site of care, and the training needs of residents, move to outpatient settings.

- **Adjusted average per-capita cost (AAPCC):** Redefine the adjustment, used to calculate payments to Medicare risk-basis HMOs, to remove from the area cost figures the cost of graduate medical education. By and large, HMOs are not supporting GME programs and assuming that they do produces excessive payment.

- **Direct medical education base year:** Per-resident amounts derived from the costs each institution had in 1984 are becoming increasingly outdated and inappropriate. For osteopathic training programs, the 1984 base year produces serious inequities. Osteopathic hospitals in 1984 relied much more heavily on volunteer faculty than they do today. Now they need to make much greater use of paid faculty and they need to provide competitive stipends for physician trainees. Use of the 1984 base period makes this difficult, since it takes no account of the relatively greater expenses that osteopathic GME programs now incur. We have consistently urged, in testimony before public bodies such as COGME and the Physician Payment Review Commission, that this problem be addressed and we again recommend that per-resident amounts be based on an adjusted national average of per-resident costs.

Thank you for the opportunity to present the views of the American Osteopathic Healthcare Association.

TESTIMONY OF AMERICAN PSYCHOLOGICAL ASSOCIATION

Psychologists as Health Professionals

The American Psychological Association (APA) is the largest scientific and professional organization representing psychology in the world. APA's membership includes more than 132,000 researchers, educators, clinicians, consultants, and advanced students. APA's mission is to advance psychology as a science and profession and also as a means of promoting human health and welfare. Psychologists study human behavior and experience and apply that knowledge to solving human problems. As an association, APA has a long history of involvement in social policy related to human behavior and human welfare. Beyond their historic role in basic research on human behavior, psychologists represent a significant force in the provision of health care services to the public.

- Psychologists provide outpatient services for mental health conditions, and for general health conditions with a significant behavioral component, in community agencies, health maintenance organizations, school systems, mental health centers, counseling centers, and independent individual and group practices.

- Psychologists provide inpatient services in municipal settings such as federal, state, county, and city hospitals, as well as at private mental hospitals.

- Psychologists also serve on the staff of psychiatric units in general hospitals.
- Psychologists provide liaison services to medical units in general hospitals, since many physical conditions are stress related, have a significant behavioral component, or benefit from assistance with psychological interventions.

- Psychologists work in residential treatment centers and in rehabilitation centers, as well as in many corporate settings that provide mental health or drug and alcohol services to employees.

Consumers of psychological services include individuals, families, public and private organizations, employers, institutions, and third party payers.

The purpose of this testimony is to describe how psychologists function as primary care providers and to explain why psychologists are essential to the provision of quality comprehensive health care throughout our nation. Accordingly, it is critical that psychologists be included in the Medicare Graduate Medical Education (GME) program.

Psychologists as Primary Care Providers

Psychology, as the science of human behavior, serves a critical role in promoting health, preventing disease and assessing and treating illness. Not only do psychologists diagnose and treat recognized mental health problems, they are essential in treating the cognitive, emotional and behavioral aspects of many general health problems.

Many patients who visit a physician do so because of symptoms they have developed as an expression of psychological distress (Sobel, 1993). Symptoms such as depression, anxiety, headache, and exhaustion, are among the most common reasons for a visit to the doctor — and all of these conditions are responsive to behavioral health interventions. Indeed, in clinical practice, at least 30% of patients who see a physician may have conditions for which no physiological or organic cause is found after routine investigation (Wilson, 1995).

Most major health problems -- heart disease, cancer, high blood pressure, stroke, and diabetes -- are caused by factors which require biopsychosocial interventions (CMHS, 1994). Successful health care requires intervention at both the biological and the behavioral aspects. Both the Surgeon General and the Institute of Medicine have observed that 6 of the 10 leading causes of death in the United States which account for 50% of all mortality, are, in part, behaviorally determined. Psychology, as the science of behavior and behavior change, is uniquely positioned to contribute to the solutions of these chronic health problems (Olmedo, 1994).

A number of researchers have shown that psychological intervention can contribute significantly to both psychological and physical health outcomes in patients with cancer (Fawzy, 1995). Aware of the benefits of these psychosocial therapeutic interventions, today's patients often specifically request such services. Interventions that are designed to help the person feel less helpless and hopeless have the added benefit of encouraging more responsibility to get well and comply with medical regimens. Further, as survival rates have improved with advances in

medical care, the importance of psychological interventions designed to assist cancer patients in dealing with diagnosis and treatment has increased (Fawzy, 1995).

Interventions developed by psychologists have proven effective in the management of different health problems, including: asthmatic episodes, irritable bowel syndrome, vasospasms associated with Raynaud's Disease, dyspnea with chronic obstructive pulmonary disease, severe headaches, and muscle spasms, insomnia and other sleep disorders, gastrointestinal ulcers, post-mastectomy and heart attack. These services have developed in conjunction with the shift in medicine from the treatment of infectious disease to the management of chronic disease. They are health care services provided daily by clinical health psychologists, and fundamental to the provision of quality, cost effective health care. Belar (1984) has argued convincingly that these services relate to the emotional and behavioral aspects of many medical problems, including:

(a) coping with illness and stressful medical procedures,
(b) the impact of stress on disease,
(c) compliance with medical regimens,
(d) the management of pain
(e) the regulation of psychophysiological symptoms,
(f) the physician-patient relationship, and
(g) the prevention of disease (through behavior change such as smoking cessation, weight management and safe sex)

Coronary heart disease is the major cause of death and disability in the Western world. One of the most comprehensive studies of behavioral interventions in severe heart disease patients has now demonstrated significant and clinically meaningful decreases in LDL cholesterol (37%), systolic blood pressure (134 to 127 mmHg), angina pain (90%), and vessel blockage on angiogram in 18 of 22 patients. Over the same year, the control group receiving standard medical treatment experienced a 165% increase in angina pain, and angiograms revealed that nearly half of the patients had increased artery blockage (Ornish, 1990).

Research related to asthma, the major cause of disability in children, is also illustrative. Research has demonstrated that a course of family therapy focused on the behavioral management of symptoms, plus systematic relaxation training, resulted in improved pulmonary functioning, increased compliance with medication, decreased use of steroid medications and decreased number of days impaired by illness in comparison to children not provided family treatment (Gustafsson, 1986). Other controlled research (Wilson, 1994) has demonstrated a 40% decrease in medical office visits for acute asthma two years after a group behavioral treatment. The systematic group treatment was also significantly more effective than individual education and information alone (Belar, 1993).

Case Study: Jack W. Finney, Ph.D., a psychologist at the Virginia Polytechnic Institute and State University, has developed a model of health care based on the recognition that parents first discuss the health and the mental health problems of their children with primary care providers. A small group of children often use a disproportionate amount of medical services without discernible benefit, usually because care seeking is related to unrecognized and untreated psychosocial problems. Therefore, early detection of, and intervention with, these problems should provide better care for the children and an alleviation of strain on the resources of the health care system. A psychological intervention service was established within a large Health Maintenance Organization. Brief targeted therapy was provided for parents and children with common difficulties such as behavior problems, school problems, toileting difficulties, and psychosomatic problems. The treatment was successful for a majority of the children and high parent satisfaction was reported. Of greatest interest, children in this program decreased their overall use of medical services. This offset effect (a reduction in the use of medical care after mental health treatment) also has been reported in studies with adults, and clearly documents the value of psychological services in a comprehensive primary care program.

Behavioral Medicine: The Role of Psychologists in Interdisciplinary Teams

Psychologists are found at every step of the primary care ladder, from primary prevention through health education, to secondary prevention with outpatient services, to tertiary prevention in inpatient programs with medical as well as psychiatric patients. They are accepted and used widely throughout the country by physicians, nurses, and other members of the health care team.

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(Linton, 1995). Further, with health care reform, there is a growing trend for joint practices between primary care physicians and psychologists to address the psychological aspects of medical problems seen by primary care physicians (Wiggins, 1995).

Psychologists currently participate on multidisciplinary teams in clinics and hospitals providing primary health care services including assessment, consultation and treatment in behavioral health. Psychologists are also found in medical settings such as pain programs and rehabilitation settings, providing services to patients recovering from a wide variety of impairments from cardiac to neurological to muscular to physical trauma, all as an integral part of a primary health care team. Psychologists perform as part of the primary care team in Veterans Administration hospitals, and the National Health Service Corps includes psychologists as part of their multidisciplinary teams in the national network of community health centers in underserved areas. Psychologists also work with family physicians in rural areas as part of primary care teams for the purpose of treating those suffering from alcoholism and substance abuse (APA, 1993).

Like other health care providers, psychologists provide evaluation, diagnosis and assessment services for both mental and general health concerns. Thus, psychologists are an integral part of a network of health care providers available to respond to the most pressing health and community problems of this nation.

Case Study: Dr. Robert Allan Ph.D., a psychologist at the New York Hospital, Cornell Medical Center, has worked with physicians in treating post-coronary patients. Since Coronary Heart Disease (CHD) is the leading cause of death in Western countries. The primary risk factors for CHD are cigarette smoking, elevated serum cholesterol, and hypertension; each of the three factors have major behavioral components in most cases. Behavioral interventions with CHD patients have resulted in a reversal of coronary atherosclerosis, a reduction in angina, and an increase in life expectancy. Among the behavioral interventions that have been employed successfully are stress management, group therapy, dietary changes, smoking cessation, and increased social support. The positive effects of the incorporation of behavioral counseling in treatment for a CHD patient are supported by research, and represent a valuable addition to the treatment regimen for coronary patients.

Role of Psychologists in Training Hospitals and Academic Health Centers

Psychologists provide a substantial share of the teaching, training, clinical supervision and direct service in Departments of Family Medicine programs that train future primary care physicians. They contribute similarly in departments of pediatrics, internal medicine and community medicine.

Case Study: The Medical Psychology Residency Program at the Oregon Health Sciences University (OHSU) is one of many residency programs administered through the Graduate Medical Education (GME) office in the OHSU School of Medicine. Three residents in Medical Psychology are appointed each year for a one-year program with residents an option to add a second year to the program. Residents in Medical Psychology interact with residents from most of the other specialties around patient care issues, as referred to Medical Psychology from one of the other specialties, usually from one of the primary care provider specialties. Patient referrals to Medical Psychology have been increasing each of the past several years because psychological assessment and intervention effectively assist in the diagnosis and treatment of many patients in the health care setting. The setting for the psychology residency program is the Medical Psychology Outpatient Clinic (MPOC). This clinic is one of many in the OHSU Ambulatory Care Department. Stipends for the psychology residents are paid in part from funds provided by the University Hospital from revenues generated from patient care in the MOPC. "In every way Medical Psychology patient care and residency training has become an accepted and integral part of health care and residency education at OHSU." (Wiens, 1995)

Psychologists' Role in Health Maintenance Organizations

Psychologists provide services in a variety of settings including community health and/or mental health centers, rehabilitation facilities, hospitals and health clinics, public schools, health maintenance organizations (HMOs), and office-based private practices. In multidisciplinary

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arrangements such as HMOs, psychologists play a critical role because they understand the issues of individual and family dynamics which contribute to the over and under use of medical services. HMOs and other managed care plans have an economic incentive to develop prevention programs that reduce unhealthy behaviors and compliance programs that encourage adherence to prescribed medical regimens.

Psychologists are uniquely trained to provide necessary services to the external and internal clients of HMOs. Approximately 35% of the U.S. population now utilize HMOs and the enrollment in HMOs is increasing rapidly. Psychologists in HMOs work with multiple disciplines (i.e. doctors, nurses, and administrative officers). HMOs rely on psychologists to train other health professionals on how to communicate effectively, especially with individuals who have different language or cultural backgrounds, and to identify organizational problems within and between departments. The psychologist in an HMO ensures that individuals are receiving appropriate treatment and that the HMO is working efficiently to deliver these services (Tulkin, 1985).

In HMOs and other settings, psychologists work side by side with pediatricians in primary care: (a) providing psychodiagnostic assessment services required to accurately diagnose learning disabilities,(b) providing consultations regarding child behavior and developmental issues (e.g., behavior management, toilet training, sibling rivalry), and (c) providing identification of high risk situations (e.g., child abuse) and the design of appropriate interventions. Indeed, one study has demonstrated a 63% reduction in utilization of pediatric medical services after psychological intervention with parents (Belar, 1994).

> **Case Study:** Dr. Gregory Hafen works in a large multi-specialty group of 450-plus physicians and psychologists with a capitated population of 350,000 patients in Southern and Northern California. Psychologists have been partners of the medical staff and part of the primary treatment team since 1988. The HMO has instituted open access to behavioral health which has developed its own internal utilization review (UR) and quality assurance (QA) procedures. Psychologists are treated as equals within the medical center and have responsibility for being the gatekeepers to more and less restrictive levels of care. In the new managed care health care market, psychologists' make a significant contribution to the integration of all medical care. Dr. Hafen notes that his organization is committed to the belief that the treatment of mind and body should be integrated. Accordingly, multi-disciplinary treatment teams for medical conditions such as pain management have been instituted. The integration of the behavioral and medical disciplines creates a more balanced and efficient treatment process in the primary care setting. Because patients get the interventions they need instead of inappropriate medical treatments (e.g., drugs in wrong dosages, and combinations), such interdisciplinary treatment is more cost-effective in the long run.

Psychological Services are Cost-Effective

Over the past several decades psychologists have assumed an increasingly greater role in the provision of mental health services. The most extensive research to date on the cost-effectiveness of mental health and substance abuse services involves the study on Hawaii's medicaid population. An analysis of 16,000 medicaid recipients showed that patients with mental health needs were higher utilizers of the medical system by 200-250%. This study also found that over a three-year period medical costs increased by 15% for medicaid patients who never used mental health services and relative to this baseline, targeted, focused mental health treatment reduced medical costs by 25-36%, depending on the comparison group (Pallak, 1991).

A study of the entire Georgia medicaid population revealed a substantial offset savings from mental health treatment. Patients receiving physical and mental health services realized a savings of $1500 over 2 1/2 years. The cost of the mental health services were entirely paid for by these savings (Feidler, 1989). Similarly, the CHAMPUS Program, which provides health care to dependents of military personnel has demonstrated that unlimited outpatient mental health services resulted in a net saving of $200 million between 1989 and 1992 (GAO, 1992).

Data from Kaiser Permanente and the Harvard Community Health Plan reveals that 50-75% of patients seen by general practitioners have complaints of physical illness that are influenced by psychological factors (e.g., indigestion, hypertension, headache, diarrhea, sleep problems, shortness of breath), and that these patients tend to use the health care system twice as often as other health plan members. Short term psychological intervention has resulted in a 47% decrease

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in medical utilization in these patients during follow-up (Belar, 1993).

Untreated alcoholism and substance abuse illustrate the consequences of failing to provide mental health services. Cummings found that individuals suffering from alcoholism and substance abuse who sought medical services rather than mental health services resulted in a rapid escalation of medical utilization with costs skyrocketing by 91% (1990). In another study, Luckey found that 1/2 the cost of treating individuals with alcoholism is offset in one year by reductions in medical costs (1987). SAMHSA has reported that the economic and social costs of untreated addictive and mental disorders were $314 billion in 1990 -- more than cancer, respiratory disease, or heart disease (Greenberg, 1993).

With respect to surgical patients, an analysis of 191 studies revealed that brief presurgical psychological intervention has been consistently associated with fewer postsurgical complications, less medication usage and an average of 1.5 fewer hospital days (Devine, 1992). Sturm and Wells have found that the reduction of one functional limitation (e.g., depression) is associated with an increase of $2,000 to $3,000 in annual earned family income. "From a public finance perspective, the increase in employment and earnings is associated with better care is likely to increase tax revenue and lower unemployment and welfare payments." (Sturm, 1995).

Psychological interventions developed for health care problems tend to be short-term and focused in nature, involving techniques as diverse as family therapy, cognitive behavioral therapy, relaxation training, and other psychophysiological techniques such as biofeedback. Numerous follow-up studies have demonstrated not only significant improvement in symptoms and quality of life, but also reductions in subsequent hospitalizations, medical office visits, medication usage and visits to the emergency room. Studies have shown that patients of physicians who received such psychological interventions reported significantly increased physical functioning, an improvement that remained stable during the year after the intervention. Such interventions reduced annual medical care charges by $289 in 1990 constant dollars, which equates to a 32.9% reduction in the annual median cost of their medical care (Smith, 1995).

Finally, researchers have noted that a large percentage of subjects with depressive disorders and panic disorders reported a disability day owing to emotional reasons (44% each). The mean days missed from work for an emotional reason ranged from 3.2 to 9.4 days, and the mean for depression was greater than that attributed to all conditions except cancer and cardiovascular problems (Kouzis, 1994). In addition, the absenteeism rate was from 10 to 33% for high risk employees compared without risks costing a total of $70.8 million annually in illness costs (Wiggins, 1995).

The Value of Including Psychologists in Medicare GME

The public, managed care organizations, and the government are calling for tight, cost-effective, widely available, integrated health care teams to provide human and comprehensive services to our citizens. Psychologists play a major role in training (over 3000 currently on faculties of medical schools and residencies), research (a massive health psychology literature used every day in the primary care field), and direct service (Linton 1995).

It is widely known that the available pool of trainees in psychiatry is diminishing. At the same time, the number of students completing graduate training in professional psychology remains stable. Indeed, within the Association of American Medical Colleges, the premier organization in medical education, there are a large number of psychologist members in the Association for the Behavioral Sciences in Medical Education, along with physician members who come from specialties such as pediatrics and internal medicine. Yet, there is very little federal support for psychology education and training (Linton, 1995).

Due to the extensiveness of scientific preparation and clinical supervision necessary for independent research and practice, an average of 7.5 years beyond the bachelor's degree is required to obtain a Ph.D. in psychology. During this time, however, students contribute to the ever growing body of knowledge, and provide direct services to patients and their families. Clearly, financial support plays a major role in attracting individuals to a particular discipline. Indeed, it is critical in attracting minorities and the financially disadvantaged (Belar, 1994).

Psychologists frequently serve as the behavioral scientist member of multidisciplinary research teams and are often the principal investigators in these projects. In addition, psychologists work with physicians and other health care providers on multidisciplinary teams in training hospitals and Academic Health Centers and in Health Maintenance Organizations. Federal support for

training psychology interns in health care facilities will allow them greater exposure to primary care, and afford them opportunities to prepare to teach, evaluate and provide services even more effectively as partners in the health delivery system (Linton 1995).

Despite the important role that psychologists play in the delivery of health care services as members of interdisciplinary teams, there has been almost no federal support for students of psychology, including minority students. Compared with assistance to the medical profession, federal assistance to psychology is minuscule (Dunivin, 1994). There is, in fact, a critical need for more psychologists, especially minorities, to work in public settings and in particular in underserved areas. Yet, without federal financial aid programs, it is nearly impossible for those who otherwise could not afford the seven years of graduate school to become a professional psychologists.

Currently, hospitals do not receive any GME funding to support psychology internship programs. This lack of reimbursement, coupled with the loss of income due to health care reforms, has forced many hospitals to reduce financial support to train psychologists. Moreover, current inequities in GME funding have lead to cutbacks in positions of hospital staff psychologists who provide training to interns, in addition to providing diagnostic, assessment, preventive, and therapeutic services to hospital patients. Linton (1995) notes that while it is unusual to find administrators who are antagonistic *per se* to the notion of training psychologists in their facilities, because they receive no GME pass-through funds, a burden is placed on them to differentially support certain elements of the health care team.

The link between financially sound training and competent health care delivery is well known. Further, a growing number of studies have shown that the provision of psychological services reduces medical utilization and cost. Indeed, psychological services produce quality health care that generates better health for the recipients of the services and, in turn, more wealth for society at large. Clearly now is time to recognize the important and critical role psychology plays in health care and to ensure that psychology students participate in the Medicare GME program for the benefit of all Americans.

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STATEMENT OF

AMERICAN SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

April 3, 1995

RE: Graduate Medical Education

The American Society of Plastic and Reconstructive Surgeons (ASPRS) represents 97% of the nearly 5,000 board certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services which improve both the functional capacity and quality of life of our patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, and cancer.

ASPRS agrees with subcommittee Chairman Bill Thomas (R-CA), that a "revolution is underway in health care which has significant implications for the future health manpower needs of the nation as well as the destiny of our major teaching hospitals." Health care reform that does not support and foster medical education will not be viable in the long run as the quality of any health system depends on the renewal of its work force.

In 1994, ASPRS commissioned a study of the plastic surgery market and workforce. The study was performed by RRC, Inc. of Bryan, Texas. Among the study's findings, we learned that substantial increases in provider workforce are expected in the next 20 years, although many underserved areas will require a long time to attract a plastic surgeon.

Taking into account the study's findings, ASPRS adopted the following positions, which are now recommended for Congressional action.

1. Continue Federal Support for Graduate Medical Education

Federal support for graduate medical education must continue to ensure that the United States will maintain a well-trained and highly qualified physician workforce. In recent years, we have observed a trend toward lower payments by third party payers to physicians and hospitals. As a result, teaching programs have become even more dependent on Medicare financial support and are less able to compensate for any funding shortfalls through payments they receive for services provided to non-Medicare patients. This is

problem is especially acute for specialties with longer training periods, such as plastic surgery, which already receives reduced financial support from Medicare beyond the first five years of training.

ASPRS opposes proposals that would further limit Medicare direct graduate medical education support to only the first three or four years of residency training. Specialties with longer training periods are as critical to the health care needs of our nation as those with the shortest training.

2. Require Third-Payer Participation in Funding Graduate Medical Education

Further, all third party payers should participate explicitly and uniformly to the financing of graduate medical education. Provisions must be made for adequate transition payments for institutions that lose residency programs.

The shift of patient care from the inpatient to the outpatient setting justifies the encouragement of residency training programs to support training in outpatient settings including clinics, outpatient surgery facilities, and physician office settings. A method of appropriately and uniformly credentialing and financing outpatient training programs should be included in any reforms Congress will consider.

3. Provide Antitrust Relief for Workforce Planning

ASPRS supports antitrust relief designed to facilitate workforce planning activities by the medical profession, including residency program directors, residency review committees, and specialty societies.

Currently, antitrust laws put severe constraints on the ability of specialty societies and residency program directors to address effectively the issue of workforce planning. Absent appropriate changes in the antitrust laws, the medical profession may be unable to effect meaningful and timely change based on the findings from workforce research.

4. Conduct Workforce Planning on National Basis

Workforce planning in plastic surgery should be conducted on a national, rather than state or regional, basis. Due to the nature and size of the specialty of plastic surgery, workforce planning for the specialty is most appropriate at the national level. We do not support the concept of using academic consortia to determine physician workforce issues because, among other things, such a mechanism would likely lead to inconsistent decisions across various regions and could be dominated by special interests.

5. Limit Number of First-Year Residency Positions to 110% of Number of U.S. Medical Graduates

This position is consistent with the views of the Physician Payment Review Commission and the federal Council on Graduate Medical Education, and has been included in a number of previous legislative initiatives, most recently the Rockefeller-Durenberger bill introduced in the 103rd Congress. Given the emerging problem of physician oversupply, Congress should strongly consider reducing the number of medical graduates who enter, train, and practice, while taking into account and accommodating the impact of any reductions on medical services to urban and underserved populations.

6. Allot Residency Positions Based on Program Quality

If the number of residency positions in any specialty needs to be reduced, the quality of the training program should be the primary determining factor in the allocation of slots. Determinations of quality should be left to the existing Residency Review Committees and the Accreditation Council of Graduate Medical Education system.

Conclusion

ASPRS gained a variety of valuable insights through its workforce study, although the Society's and the specialty's ability to utilize that information to make appropriate changes in plastic surgeon workforce supply is limited because of current antitrust prohibitions.

ASPRS appreciates the opportunity to testify on the topic of graduate medical education before the Subcommittee on Health, and would be happy to be a resource as the Subcommittee and full committee continues its work on this complex issue.

April 3, 1995

STATEMENT OF THE MAYO FOUNDATION

COMMITTEE ON WAYS AND MEANS, HEALTH SUBCOMMITTEE

MARCH 23, 1995

The Mayo Foundation is an integrated health care system, with clinics, hospitals, and other health care entities located in five states. These include Mayo Clinic Rochester, Saint Marys Hospital, and Rochester Methodist Hospital, in Rochester, Minnesota; Mayo Clinic Jacksonville and St. Luke's Hospital, in Jacksonville, Florida; and Mayo Clinic Scottsdale, in Scottsdale, Arizona. We have also merged with Mayo regional practices and hospitals in Minnesota, Iowa, and Wisconsin. We serve patients from all fifty states and many foreign countries. We are engaged in research and education, with over one thousand residents in training at multiple locations.

As the Congress develops policies for graduate medical education, we believe that serious attention must be given to separating funding for education from patient care revenue. In the past, teaching institutions were able to cross subsidize education programs from patient care revenues. In today's world of managed care and market competition, this ability is severely limited. We strongly support a market-based health care delivery system, and see many efficiencies coming from this competition. However, for competition to work there must be a level playing field. In order to create such a level playing field, societal goods, such as research and education, should be funded by all the participants in the health care system.

In the long run, a separate funding pool must be created for graduate medical education. This pool could be funded by a surcharge on all health premiums and distributed on a per resident basis to the programs that incur the costs of the education. In the short run, it is imperative that the government maintain a fair level of Medicare funding for graduate medical education through the DGME and IME payments.

We suggest that the DGME payment system be simplified and made fairer by making several changes. First, a uniform payment level should be established. There is neither fairness nor good policy sense in the tremendous variation in per resident payment levels that exists today. Second, the payments should be made on a per resident basis, regardless of the type of setting in which the resident is training. Good education policy requires that residents receive more of their training in non-hospital settings, yet the payment mechanism is limited to hospital-based training. Moreover, integrated health care systems are working to make sure patients are treated in the most efficient setting, and the lines between hospital and clinic are often not clear.

We also urge you not to establish graduate medical education funding on a state basis. Mayo participates in a national and international education market. We recruit residents and students from all parts of the country, and train them to meet national needs. Any attempt to apportion residency training funds on a state-by-state basis will seriously disrupt this market. The Mayo Graduate School of Medicine (our residency training program) is one of the largest, and we believe one of the best, training programs in the country. However, it is based in Rochester, Minnesota, a city of less than 75,000 population. If residency funding were to be distributed by state or region based on population, we would have to shut down most of our programs. In this arena, we believe that a working market will allow the best training programs to survive, and poorer programs will shut down for lack of trainees.

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STATEMENT OF THE SOCIETY OF GENERAL INTERNAL MEDICINE

The Society of General Internal Medicine (SGIM) was founded in 1978 to promote improved patient care, teaching and research in primary care general internal medicine. There are approximately 2,700 members of SGIM. The importance of generalists to the nation's health care system and the critical role they play in effecting reform in health care delivery has long been recognized by the profession, by the nation's policymakers, and by society. Recent efforts to reform the nation's health care delivery system reaffirmed the role of the generalist physician in providing universal access and controlling costs. The unique contribution of generalist physicians to health care delivery is their ability to provide comprehensive high quality primary care in a variety of settings, to people with a broad array of health-related conditions. Generalist physicians are specially trained to deliver primary care. Primary care is characterized by first-contact care for patients with undifferentiated health concerns; patient-centered comprehensive care that is not organ or problem specific; continuous, longitudinal patient care; and coordination of necessary medical, social, mental, and other services through appropriate consultation and referral. General internists provide this type of primary care to men and women from adolescence through old age.

We commend Chairman Thomas in addressing current graduate medical education (GME) and teaching hospital policy. In examining alternative policies regarding the training of future health professionals, the needs of the health provider in the evolving health care system, and the financing of teaching hospitals, the committee must also consider the series of disincentives related to the generalist disciplines from undergraduate medical training through practice:

1. Financial and other incentives have pushed an increasing number of international and U. S. medical graduates into specialist careers. Despite one of the highest physician to population ratios, the U. S. has shortages in important areas of its health care providers.

2. Federal funding of training after medical school (graduate medical education) promotes hospital-based training of specialists who provide expensive services at low cost to the hospitals.

3. Medical students have strong incentives to choose specialist careers because of increasing indebtedness from medical school and the higher income potential of specialty as opposed to primary care practice.

4. There has been continued and increased demand for specialty services, despite concerns that many procedures and specialty services are overutilized.

Market forces alone will not correct for the low proportion of primary care physicians; the Federal Government must reevaluate and establish specific goals in the financing of medical education and medical practice. The outcome of these goals should be to achieve at least 50 percent of U. S. physicians practicing the generalist disciplines of general internal medicine, general pediatrics and family medicine.

Among the various mechanisms which have been proposed to shift graduate medical education payments to support the training of generalist physicians, we believe that the most effective short-term approach will be to modify payments to hospitals. In July, 1994, the Department of Health and Human Services Office of the Inspector General (OIG) issued a final audit report, "A Study of Graduate Medical Education Costs." The report analyzes hospital graduate medical education costs during the first 5 years of Medicare's prospective payment system, which began October 1, 1983. The report concludes that, in the absence of changes to GME through health system reform legislation, the Health Care Financing Administration (HCFA) should reevaluate Medicare's policy of paying GME costs for all physician specialties. As part of this reevaluation, the OIG recommended that HCFA consider submitting legislation to reduce or even possible eliminate Medicare's investment in GME for specialties for which there is a surplus of physicians.

Our comments address several issues related to policy reform concerning funding graduate medical education:

All Payer System

The Federal Government's financing of medical education should support training that ensures generalist physicians as the primary providers of medical services. SGIM strongly supports the reform of funding of residency training to include contributions from all payers. The per resident amount must be sufficient to cover the costs of training. Funding must also cover the costs of educating residents in all outpatient settings, not just those limited to hospital ambulatory sites. This is necessary to improve primary care training, which should include more time in ambulatory settings, training in managed care, and geriatric training. Funds for medical education should be allocated directly to training programs approved for residency training positions, rather than teaching hospitals. This will encourage the use of residency training funds for ambulatory care.

Limit Residency Training/Payments to Residency Programs

SGIM supports the following approaches to encourage primary care residencies:

1. Limit the number of years covered by direct medical education and indirect medical education payments to residency training.

2. Increased medical education payments should be allocated to general internal medicine and general pediatric residency programs which develop a primary care curriculum and establish appropriate ambulatory training sites.

3. In addition to limiting Medicare payments for residency training, the total number of first-year residency positions should be limited by capping slots at 110% of the number of U. S. medical school graduates.

4. Establish higher weighting for primary care per-resident amounts.

5. Graduate medical education funds saved through reductions in specialty residency support should be made available to primary care directors to support loan forgiveness.

Transition Payments

Transition payments should be provided to teaching hospitals which are required to reduce their residency training programs. The GME payment plan should ensure that institutions that care for disproportionate numbers of disadvantaged patients are funded adequately to ensure that the necessary replacement staff are hired. Also, we recognize that non-physician practitioners may be required to replace residents in some inpatient services at teaching hospitals. Mechanisms should be considered to provide temporary funding to support the introduction of some non-physician practitioners on certain specialized services. This would provide incentives to promote the shift to fewer specialty training positions in teaching hospitals during this time of transition.

Support for Training Primary Care Teachers

There is an increasing demand to train more primary care generalist physicians, however, there are not enough teachers to train these generalists.

Current Medicare policy limits direct GME funding to the number of years required to become board eligible in a particular specialty, or five years, whichever is shorter. General internal medicine, general pediatrics and family medicine each require three years of residency training.

Graduates of the three year residency programs typically spend two years in generalist fellowships in order to pursue careers as faculty in general internal medicine. Generalist fellowships are structured to provide the trainee with teaching and primary care research skills. Since the fellowships are not directed at training subspecialists and no board examination is

administered following completion of the generalist fellowship, institutions which train generalists for academic positions are not eligible for GME funding. Medicare GME policy currently supports only those fellowships which result in specialization and/or additional board certification.

Medicare policy should allow payment of direct GME funding for training generalist teachers. Guidelines for program funding should be established by the Secretary of Health and Human Services. Enclosed is proposed language to amend the Social Security Act in order to allow payments for fellowship training in a generalist discipline.

Proposed Changes to the Social Security Law to Support Training for Primary Care Teachers

42 USC and 1395 ww (h)

Sec. 1886 (h) Payment for Direct Graduate Medical Education Costs

(5)(A) Approved Medical Residency Training Program -- The term "approved medical residency training program" means a residency or other postgraduate training program, participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary and formal postgraduate training programs that provide fellowship training in general internal medicine, general pediatrics or family medicine approved by the Secretary, participation in which leads to a faculty position in general internal medicine, general pediatrics or family medicine.

(5)(F) Initial Residency Period -- The term "initial residency period" means the period of Board eligibility, except that --

(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program or a preventive medicine residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period, and

(iii) a period, of not more than two years, during which an individual is in a fellowship program in general internal medicine, general pediatrics, or family medicine which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, even though these fellowship years do not count towards Board eligibility or certification.

(suggested language underlined)

Conclusion

A reconfiguration of our nation's health care delivery and financing systems is necessary in order to achieve a more balanced system with expanded preventive and primary care services. We commend the committee for their efforts to restructure graduate medical education funding. The Society of General Internal Medicine is committed to working with you in further developing our policy recommendations and ensuring budget neutrality.

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April 6, 1995

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas:

Thank you for the opportunity to submit for the record these remarks to expand on the American Medical Association's Statement filed at the March 23, 1995 hearing on graduate medical education (GME) financing. We believe these comments will be useful in better understanding our positions regarding the critically important GME financing and physician workforce planning issues.

Our Statement declared that "Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and self-insured industry or government plans are generally unconcerned about the individual components of provider costs, particularly GME costs, as long as they are able to obtain competitive prices by negotiating discounts from stated charges." The intent of our comment is that HMOs, PPOs, and self-insured industry or government plans are concerned about the price they pay for services and the outcome to the patient. We are well aware that managed care plans track individual components of provider costs in an effort to curtail overall costs. While benefitting from GME programs, these plans have not evidenced a willingness to assume explicitly their fair share of GME costs.

Our discussion of some of the problems that have resulted from the evolution of GME financing, noted that "the current methods of financing GME have made it difficult to establish primary care GME programs in settings other than hospitals, such as non-hospital based ambulatory settings and rural health clinics." While it is true that the current methods of financing GME have created obstacles to the establishment of GME programs in non-hospital settings, nevertheless, a number of residency training programs, chiefly in family medicine, have been established in such settings (despite a lack of easy access to a source of funding). Progress has been made in this regard, but there still exists the need to emphasize and encourage the development of, and adequate funding for, primary care GME programs in non-hospital settings.

We would like to clarify our statement regarding the effect of the Prospective Payment System (PPS) on GME, that "...teaching hospitals have generally done better than non-teaching hospitals under PPS...." While this is true in general, we would like to point out that it is not so in the case of each and every teaching hospital, especially many public hospitals serving predominantly indigent patients. Furthermore, even though some teaching hospitals may have benefitted under PPS (as compared to non-teaching hospitals), such hospitals carry additional costs related to education and patient mix. Clearly, both PPS and RBRVS (the Resource Based Relative Value Scale) have had an important impact on GME financing. In any future design of GME reimbursement, these significant differences between teaching and non-teaching hospitals must be taken into consideration.

Our Statement, in the section entitled "Goals," declared that "the AMA believes that reform should achieve long-term stable funding of GME to ensure that all graduates of U.S. medical schools will be able to obtain, at the very least, GME leading to eligibility for initial board certification and result in increased accountability for the total number and specialty mix of GME positions, the appropriateness of the site of GME training, and the appropriateness of both the content and length of training requirements." Our use of the word "reform" here (and throughout the document) should not in any way be construed to indicate a preference for government based reform. Change is needed, but it ideally should continue to emanate from private sector initiatives with significant input from the medical profession. We would like to make it perfectly clear that the AMA is not advocating here the involvement of government in mandating how medical residency training programs should operate.

In our discussion of "Principle #1," we recommended that "all payors be required to adopt the Medicare approach for determining their share of the direct costs of GME." While the Medicare methodology for determining GME cost sharing is currently the only complete and tested model we have to look to, the AMA does not mean to imply that it should be adopted without question. Rather, we believe that an approach could be designed that is similar to Medicare's approach

which may offer an improvement in methodology.

We also discussed, under "Principle #3," an option whereby Medicare could make its participation in GME financing contingent on individual hospitals requiring the participation of all payors with beneficiaries hospitalized in each institution. Such an approach might be less viable, depending on the sophistication of a given market. Our point is that teaching hospitals will have to find innovative ways to negotiate with these payors.

In our discussion of "Principle #3," we stated that "the AMA believes that efforts to reform GME financing should not be burdened in the immediate debate by attempts to resolve these very complex issues of uncompensated care and the effect of discount contracting on the financial stability of some teaching hospitals." Our intent here was to express the opinion that such complicated issues as these will continue to adversely affect the financial stability of teaching hospitals. In the meantime, there is added urgency to appropriately develop a reasonable and fair method for GME financing.

"Principle #4" discussion remarked that "the AMA recommends that HCFA rewrite existing regulations to define more precisely the faculty salary costs and general overhead costs that may be allocated to GME." More specifically, regulations should be promulgated to limit faculty salary costs to the time faculty are directly involved in the administration of GME programs or in the supervision of resident physicians under circumstances in which no separate bill is submitted for professional services either by the physician or the hospital." Our intent here was to point out a subject matter in need of attention (i.e., variations in faculty salary costs) and one example of a manner by which to address the subject. Actually, the preferred way to address the issue, in our view, would be to do so administratively through the individual health care institutions rather than through the promulgation of regulations. The point we were trying to express here relates to the goal of achieving modernity in reimbursement methodology for GME.

In addition, under "Principle #3," we commented that "at present, decisions regarding specialty training issues are controlled, for all practical purposes, by the specialty boards and the ACGME." It should be added here that the individual residency training program directors also have wide latitude in making decisions on residency positions and on other specialty training issues. Also, as a footnote to our recommendation that annual surveys should be conducted to document variations in faculty and overhead costs among teaching hospitals, the Subcommittee should note the fact that the American Association of Medical Colleges (AAMC) currently conducts similar such surveys.

Our conclusion stated that "The AMA has considered the issues surrounding financing reform in GME and has developed goals and a set of principles to assist the national debate on this issue. The AMA believes that such reform is warranted in order to control the costs of GME, to stabilize the funding of GME, and to improve the accountability of the GME system to society so that national physician workforce objectives are achieved and maintained." Our intent here was that such national physician workforce objectives be achieved and maintained primarily through private sector initiatives.

In closing, again, we are very appreciative of the opportunity afforded us by the Subcommittee to submit these comments. As was expressed in our March 23rd Statement, we thank the Subcommittee for soliciting our thoughts and recommendations on this highly complex issue of financing graduate medical education. We look forward to working with other affected organizations and hope that we can be a continuing resource as the Subcommittee and full Committee develop their proposals.

Sincerely,

William E. Jacob, M.D.
Member, AMA Board of Trustees
Associate Provost, Academic Health Center
University of Minnesota

cc: Members of the Subcommittee on Health, Committee on Ways and Means

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